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Footnotes, bibliographies and legends should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodicals with volume, page, and year.

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NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest

to physicians. We shall be glad to know the name of the sender in every instance.

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VOLUME 1

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EDITORIAL

SOMETHING TO VOTE ABOUT

American citizenship may be acquired in the delivery room or the courtroom, but it is fully achieved only in the daily realization of those privileges and duties that give man his rightful place in society. Yet when it comes to voting—the keystone of citizenship—Americans in the past have had a tragic apathy.

In 1948 there were approximately 96 million eligible voters in the United States. But in that year, only 49 million—about half of the eligible voters—cast ballots in the Presidential election! And the turnout at the polls has been decreasing!

Such a record in America, where free elections protect the rights and liberties of the individual, is more threatening to our freedom than any threat from abroad.

In recent elections, according to the Saturday Evening Post,* the voters in leading countries exercised their right of franchise as follows:

Belgium.....	90 per cent
Italy.....	89 per cent
Great Britain.....	82 per cent
France.....	75 per cent
Japan.....	70 per cent
United States.....	51 per cent

Why are Americans so apathetic? Why do so many of us sit back and “let George do it”? Perhaps it isn’t apathy. Perhaps it is basically an unawareness of issues.

Japan had a new-found individual freedom when 70 per cent of its voters cast their ballots. France and Belgium had just dropped the Nazi yoke. England turned to Churchill after years of Socialist rule. Italy arose against Communist infiltration. People in those Nations really had something to vote about.

Americans have something to vote about, too. Daily the issues are growing more clearly defined. The world needs a strong, sure America—and only Americans can keep our Nation strong.

Our role is clear. Whatever path we want America to take, we citizens at the grass roots must make the choice. We must study the issues. We must decide. We must vote. And as good citizens, we must do everything in our power to see that others register and vote, too—because today we Americans, of all the peoples of the world, have something vital to vote about!

* January 12, 1952. Pp. 10, 12.

Reports

COMMITTEE ON RURAL MEDICINE

SUMMER PRECEPTORSHIP JUNIOR MEDICAL STUDENTS

The Committee on Rural Medicine is considering a summer preceptorship for Junior Students to rural practitioners. Any rural practitioner who is interested in securing a junior student to assist him through the summer months and is willing to pay him should contact Dr. Page C. Jett, Chairman, Committee on Rural Medicine, Prince Frederick, Maryland.

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee for the Study of Pelvic Cancer met in the Small Hall of the Medical and Chirurgical Faculty Building at 5 P.M. on March 20th, 1952. The following members of the Committee were present: Dr. Richard W. TeLinde, Chairman; Dr. Beverley Compton; Dr. C. Bernard Brack; Dr. Everett S. Diggs; Dr. Howard Jones, Jr.; Dr. Theodore Kardash; Dr. Emil Novak; Dr. Mark V. Ziegler. Total attendance 22.

For the benefit of the doctors attending the meeting for the first time, Dr. TeLinde explained that the purpose of the Committee is educational and not critical. It is the hope of the Committee that all may profit by the free discussion of cases.

CASE DISCUSSIONS

CASE I. M. D. White. Widow. Age 49 years. Para. 1. April 1950 onset of excessive vaginal bleeding for two days; two days later bleeding again for two days. Reported to clinic—was examined—Rx. hospitalization for biopsy and probably hysterectomy. Operation 5/16/50: D. & C.; hysterectomy; bilateral salpingo-oophorectomy. At operation found to have squamous cell carcinoma of cervix, Grade II. Readmitted to hospital July 1950 to attempt radium to cervix. The cervix was so destroyed by disease that radium was not used and x-ray advised. Had series of fifty x-ray treatments. Hospitalized for five weeks November—December 1950—thrombophlebitis. Occasional spotting since operation in May 1950 but never in any great amount until one week before admission to second hospital in November 1951. Saw doctor A in interim—last time September 1951—was examined and fur-

ther x-ray advised but patient could not afford this. Reported to gyn. clinic of second hospital November 1, 1951. Four days later, when having profuse bleeding, came to accident room of second hospital and was admitted to the hospital. Diagnosis: Squamous cell carcinoma, cervix. Radium.

Chairman: Is there any discussion of this case?

Guest surgeon: This patient consulted her family doctor soon after the second episode of bleeding and was immediately referred to the hospital. On pelvic examination we found that she had a large mass on the left side of the pelvis, and a large mass also on the right. Although she had been referred because of a fibroid we felt that she had far advanced P.I.D. of a type not often seen these days. At the time of operation we did the D. & C. first. The cervix looked normal and the tissue looked normal. We proceeded with the abdominal operation. A large hydrosalpinx was revealed on the right and also a large mass on the left. When deciding whether to do a panhysterectomy or a supra-vaginal hysterectomy a large mass was felt in the cervix which was considered stage II, or possibly stage III, carcinoma of the cervix. The decision as to what to do was difficult. We debated leaving the uterus in but felt that the blood supply to the uterus had already been embarrassed. There was so much pathology in the upper pelvis that it was decided to go ahead with the fundectomy and bilateral salpingo-oophorectomy. I would like to note, because it is not on your abstract, that the

patient had a 4 plus Wassermann. I feel that I made two mistakes in this case: (1) not taking a biopsy first, even though the cervix looked normal; (2) taking off the fundus. The patient was referred to a radiologist after her discharge from the hospital. It is my understanding that the patient had x-ray before her admission to the hospital for attempted radium insertion. The services at the hospital changed soon after the patient was operated on in May and I did not see her again.

Chairman: We are very glad that you came to the meeting today. You have presented just the facts that we want to know. Unfortunately this was an inverting type of tumor where the cervix can look normal. I would like to ask what was the hurry? Why not wait for a biopsy report?

Guest surgeon: It would certainly have been wiser to wait for a biopsy report. In this case the family doctor thought the patient had a fibroid, we thought she had P.I.D. That was the pre-operative diagnosis.

Visiting surgeon: If a patient is bleeding, has a fibroid, but a normal cervix, is it necessary to waste time before doing a hysterectomy? In our hospital over a period of five years and 1200 hysterectomies there has been only one case of carcinoma discovered which was not known pre-operatively.

Chairman: Certainly we have to be practical about this. On our service, however, a biopsy is done on all women on whom a hysterectomy is contemplated, and we wait for the result.

Committee member: I feel the more biopsies done, the better it is. The same applies to smears. The service here on smears is good but slow unfortunately. There is a delay of about four weeks before the report is available.

Visiting pathologist: In our hospital over the past year there has been only one case of carcinoma detected at operation and not known pre-operatively. I do not know the exact number of cases but it would be between two and three hundred.

Visiting surgeon: If adenocarcinoma of the fundus is found at operation, would you follow with deep x-ray therapy?

Committee member: We would not unless there was obvious spread of the disease. If there was spread of the disease well into the parametrium, we would use x-ray.

This was the consensus following some discussion of this question.

Visiting surgeon: In the case we have under discussion, I would like to ask if the patient had any treatment from the time of operation in May until the attempted radium in July?

Chairman: We have a letter from the radiologist which states that the patient had twenty-eight x-ray treatments between June 5, 1950 and July 7, 1950, using two anterior and two posterior ports, and using routine 200 KV technique and giving 250 r as measured in air at each treatment. Of the attempted use of radium he says, "all ordinary anatomical landmarks were completely obliterated and I thought it good judgment not to place radium into what remained of the vaginal vault. Between July 17, 1950, and July 29, 1950, I gave her eight intravaginal and four perineal x-ray treatments. Altogether she received 5000 tissue r to the cervix and parametrial area. . . . The patient returned to me again on June 11, 1951. At this time there was an obvious gross recurrence. Between June 11, 1951, and July 5, 1951, I gave her twenty more external x-ray treatments as a palliative measure. I did not see her again."

It is noted on the abstract of this case that the patient was advised to have further x-ray in September 1951, but stated that she could not afford this. Not in reference to this case, but just by way of information I would like to say that there are some funds available through the American Cancer Society for treatment.

Visiting surgeon: Would it have been advisable for this patient to have further x-ray? It is the usual belief that when a patient has had sufficient x-ray the second dose does no good.

Committee member: There is good salvage but terrific radiation reaction after passing the critical dose.

Case I: No Delay.

CASE II: E. C. White. Age 68 years. Married. Para 4. Menopause, 1934. About December 10th, 1951, sudden profuse brownish vaginal discharge, followed by intermittent vaginal bleeding. Consulted doctor A a few days after onset of symptoms—was not examined—pills prescribed. Consulted this physician again in late December—was not examined. Consulted doctor B January 10th, 1952—was examined and hospitalization recommended. D. & C. and biopsy February 5th, 1952. Referred to second hospital for treatment. Diagnosis: Carcinoma of the fundus. Radium. Panhysterectomy.

Chairman: Unfortunately the doctor who first saw this patient is not present today. This case follows

a pattern we see all too often. The patient consults a physician, is not examined and pills are prescribed. The patient does not improve, consults another physician and immediately receives proper examination and treatment.

Case II: Physician Delay.

CASE III: F. R. Colored. Age 16 years. Single. Patient seen in gyn. clinic July 16, 1951, with complaint of "dizziness, knot in thigh, pains in stomach." Pelvic negative. Impression: "Femoral hernia; adenitis with cyst. formation." L.M.P. October 1951. Patient thought she was pregnant; felt weak and ill. Consulted doctor A, November 1951. Was examined and told that she was not pregnant but that she had low blood pressure and "inflammation of the stomach." Treated with oral medication and penicillin injections. Saw doctor A four times. Continued to feel ill. No menses except for one day in December. Went to second clinic January 25, 1952. Ectopic pregnancy suspected and patient was referred to the hospital and hospitalized the same day. Diagnosis: Retro-peritoneal lymphosarcoma. Exploratory laparotomy January 28, 1952. X-ray.

Committee member: I happened to be at the second clinic the day this patient presented herself. She gave a history of not menstruating for about three months. A mass could be felt in the abdomen adjacent to the left inguinal canal. On pelvic there was no evidence of a pregnancy of three months. The first impression was a possible ruptured ectopic pregnancy which was walled off. The patient looked ill and was referred to the hospital immediately. I did not examine the extremities and did not know of the mass in the thigh at this time. We did not expect a malignancy in this sixteen year old girl with amenorrhea.

Committee member: The record does not say whether or not the patient was referred to the surgical clinic after she was seen in the gyn. clinic in July with the impression of "femoral hernia." Knowing the patient it is possible that she was referred and did not keep the appointment. She should have been referred to surgery. The mass, of course, proved to be the sarcoma presenting into the inguinal canal.

Chairman: This is an unusual case and everyone probably did the best they could. I do not believe we can say there was delay here.

Case III: No Delay.

CASE IV: M. F. Colored. Age 71 years. Widow. Para 3, 1 miscarriage. Menopause about 1920. Beginning in October or November 1949, slight vaginal discharge. February 1950,

slight vaginal spotting, intermittent but increasing in amount. Consulted doctor A in February 1950. Was examined and told there was nothing wrong. Bleeding increased and by June 1950 was almost continuous. Again consulted doctor A and was referred to the hospital June 1950, and hospitalized. Diagnosis: Adenocarcinoma, corpus uteri, Grade III. Radium. Hysterectomy, total abdominal; suture of cervix; salpingo-oophorectomy, bilateral.

Question raised as to why the suture of the cervix after radiation therapy had been carried out. It was felt that in some cases where this is not done that there can be a vault recurrence.

There was a long discussion of "that American institution," the insistence on preliminary radiation in carcinoma of the fundus. The consensus was that there is a higher percentage of salvage when radium is used as an adjunct to surgery.

Visiting surgeon: Then why do we not follow the same line of thought in treating Stage I carcinoma of the cervix? I mean a total hysterectomy, not a Wertheim, following radiation.

Chairman: It seems to me that if spread beyond the cervix is trapped by fibrous tissue that opening up the abdomen would be the worst thing you could do.

Committee member: If the case does well with radiation it is better to let it stay as it is.

Case IV: Patient and Physician Delay.

CASE V: M. E. White. Age 54 years. Married. Para 7. L.M.P. July 1950. Patient had an appendectomy April 1951. About one month after operation began to have scant, intermittent bloody vaginal discharge. Beginning August 1951, profuse foul-smelling watery discharge. January 15th, 1952, profuse vaginal bleeding with large clots. Consulted doctor A—was examined and referred to hospital for D. & C. and biopsy by doctor B. Biopsy January 21st, 1952 showed squamous cell carcinoma. Patient referred to doctor C for treatment. Admitted to second hospital January 27th, 1952. Patient found to have a vesico-uterine or vesico-cervical fistula. February 5th, 1952, D. & C. and biopsy by sharp conization; exploration of fistula. Pathological report "carcinoma in situ" . . . "one fragmented area suggestive of invasion." February 11th operation: Cystotomy; biopsy of bladder; bilateral ureterosigmoid implantation. Post-operative diagnosis: Carcinoma of cervix; carcinomatous and traumatic fistula, cervico-vesical. Patient to be treated later with radium and x-ray.

Guest surgeon: This patient had an appendectomy, according to her history, on April 27th, 1951. The brief abstract which I have received from the hospital states that the physical examination was essentially normal and that the pathological findings

at operation showed a scarred appendix. It was not stated whether or not a pelvic examination was made at this time.

Chairman: I believe we have a note from the hospital saying that according to the history and physical taken at the time of admission there was no pelvic examination done.

Guest surgeon: A month to six weeks following the operation the patient began to have an occasional bloody discharge from the vagina and in August 1951 began to have a profuse, foul-smelling watery discharge. Following profuse bleeding on January 15th she was sent into a hospital for a D. & C. and biopsy. The doctor who performed the D. & C. told me that he felt he had perforated the uterus at the time of operation. The patient was catheterized and blood-stained urine was obtained but when methylene blue was introduced into the bladder to determine the presence of a possible fistula, no dye leaked into the vagina. Cystogram examination the next day was read as normal. Three days following discharge from this hospital I saw the patient for the first time. At that time she was pouring urine

from the vagina but I could not see the fistulous opening. She was admitted to the hospital. On examination, milk put into the bladder came through the vagina. The first two biopsies done showed chronic cervicitis. On re-reading the slides from the original biopsy at the first hospital it was thought there was some evidence of carcinoma in situ. The third biopsy at our hospital was as stated in the abstract. The patient was operated on as stated, and will be treated with x-ray and radium. We are treating her as invasive carcinoma.

Committee member: I would like to ask why the bladder was opened at the time of operation?

Guest surgeon: With the idea of closing the fistula if that seemed possible. The fistula proved to be too large.

Committee member: Did the biopsies from the fistulous tract show carcinoma?

Visiting pathologist: No, the biopsies from the fistula were not positive for carcinoma.

There was discussion of the urological problems involved in this case and the advisability of doing a cystotomy at the time it was done.

COMMITTEE TO COOPERATE WITH THE AMERICAN MEDICAL EDUCATION FOUNDATION

NEWLAND E. DAY, M.D., *Chairman*

At a really stimulating meeting of the American Medical Education Foundation, February 17th in Chicago, Maryland physicians will be proud to know that they have no need to apologize for the interest they have already shown in the Foundation. In spite of its size, your Chairman of the State Committee was informed that we were fifth from top place in contributors of all the States from January 1, 1952 to February 14, 1952.

The Faculty's activation of this Committee took place in late December past, a move which had been delayed in the past year by other local and pressing needs such as our own Building Fund Campaign so ably directed by Dr. Goldstein. Following the appointment of a Chairman and City and County members, an initial letter outlining the purpose of the American Medical Education Foundation with a request for support was made with the knowledge

that Maryland doctors when they are given the facts know where their duties rest and will not shirk them.

The initial response was most gratifying. Many who gave generously, not only contributed but wrote that they were "happy" to give, to a program that helped to save their corner of America for others to come. The spirit of the givers was of more significance than even the totals reported. Members of the Medical and Chirurgical Faculty gave before an explanation was furnished that contributors to the Foundation may select the recipient of their gift as follows: (1) " earmark " it for any accepted Medical School of their choice, (there is no deduction for administrative expenses) or (2) authorize the Foundation to distribute the gifts to all medical schools on a proportionate basis.

The American Medical Association pays the bill

for administration. It is possible for your Alumni Association and yourself to be given the credit for any gift and the Foundation at the same time is also helped. There are many private organizations willing (and already pledged) to match the Medical Profession's contributions. The gift is *Tax Deductible*. Maryland reported that in the period from January 1, 1952 to February 14, 1952, contributions totaling over \$1,027.00 had been forwarded to the Foundation.

State reports were preceded by an address of welcome by the President of the A.M.A., Dr. E. L. Henderson, who is also President of the A.M.E.F. This was followed by an address by Dr. James E. Almond, a pioneer in the field of fund-raising for American Institutions. In the afternoon the goal, the plan and the mechanics of the American Medical Education Foundation were explained.

Colorado, with 1100 members in its State Society contributed \$8,000.00. In Indiana, one county alone with only 18 members pledged over \$1,300.00, another county also of 18 members pledged \$1,800.00. Emphasis was placed on each member's contribution and not totals. Thus far this year Indiana has reported 383 contributors with total contributions of over \$20,000.00

In 1951, America's 6,135 new doctors of medicine paid only 25% of the cost of their medical training. It cost more than \$13,356 to train each of them. Most of this differential represents medical schools operating deficits, which we as a profession must help meet, or it will be done by other groups less concerned with the problems of the individual schools and doctors and more concerned with an increasing concentration of power.

In July, 1951, the American Medical Education Foundation made grants to every recognized medical school in America under the following classifications. Class A schools received uniform grants (\$15,000.00 to each school in 1951) across the board regardless of special needs. Class B schools received grants of money on a per capita basis of student enrollment.

Class C schools participated in a special fund contribution on the basis of special or unique problems of financial strain. This latter class showed benefits out of all proportion to the amounts given. In many instances it meant the difference in keeping key teaching and allied personnel. FUNDS DONATED TO THE SCHOOLS ARE UNRESTRICTED AND MAY BE USED FOR ANY PURPOSE. What a contrast this makes to those areas in which the Federal Government lends its helping hand.

What is our goal this year? One million dollars from the A.M.E.F. (that's you, doctor) and a total of \$5,000,000 from the combined efforts of the National Foundation for Medical Education (which handles the lay contributions).

Why not encourage your Alumni Association to make its contribution through the A.M.E.F. with the association receiving full credit and the school getting all "earmarked" funds PLUS THE AMOUNTS THAT WILL BE CONTRIBUTED BY THE FOUNDATION TO EACH SCHOOL?

LET'S PUT MARYLAND IN THE LEAD WITH AN "EVERYMAN" CONTRIBUTION. THIS FOUNDATION IS A GREAT WORK AND HAS WON THE WHOLE HEARTED SUPPORT OF SUCH MEN AS DR. HARVEY B. STONE, WHO IS VICE-PRESIDENT OF THE FOUNDATION.

SEND THIS TAX-DEDUCTIBLE CONTRIBUTION either to your County representative or the Medical and Chirurgical Faculty made out to A.M.E.F. If you care to "earmark" it, make the notation on your check. You will receive a receipt acknowledging this from the A.M.E.F. as well as your school.

The members of the Committee to Cooperate with American Medical Education Foundation are as follows: Doctors—Newland E. Day, *Chairman*, Thurston R. Adams, Walter E. Baetjer, J. H. Bates, Stuart Christhilf, Jr., H. V. Davis, Charles R. Foutz, J. Stanley Grabill, William B. Hagan, W. H. Sprecher, L. A. Hoffman, Philip A. Insley, Ernest F. Poole, Theodore R. Shrop.

SUMMER HOURS FOR THE FACULTY BUILDING

June 16, 1952 to October 1, 1952

Monday through Friday—9 a.m. to 5 p.m.

Saturday—9 a.m. to 1 p.m.

COMMITTEE ON INDUSTRIAL HEALTH

N. B. HERMAN, M.D., *Chairman*

OCCUPATIONAL DISEASES

An amendment to the Maryland Occupational Disease Law, effective June 1, 1951, made all diseases contracted as a result of and in the course of employment compensable. Previously, only the diseases specifically listed in a schedule were compensable.

Most, if not all, occupational diseases are preventable through the cooperation of the physicians, industries and the health department. Recognizing this requires the physician attending or called in to treat a patient whom he *believes* to be suffering from an ailment or disease contracted as a result of the nature of employment to report the case to the State Health Department, or to the Baltimore City Health Department. The post card used for report-

ing communicable diseases is also used for reporting occupational diseases.

Of 202 cases occurring in Baltimore that were awarded compensation for occupational diseases during 1950, only 4 were reported by the attending physicians to the City Health Department.

The Health Department can discharge its part of the cooperative responsibility in preventing occupational diseases most effectively when the physician attending a case that he *believes* to be related to the patient's occupation reports promptly.

It is believed that this should be of interest to the practicing physicians of Maryland since, according to statistics compiled by American Medical Association, between 80-90% of cases of Occupational Disease are first seen by the family physician.

COMMITTEE ON PUBLIC MEDICAL EDUCATION

Baltimore City Medical Society

Capital Capsules

H. HANFORD HOPKINS, M.D.

February 2, 1952

Take a letter

Commissioner of Internal Revenue, John B. Dunlap, wrote a letter to 52,000,000 tax payers this month telling them how to make out their income tax. It was typed in blue, and in large letters said, "Please read this carefully." Here are some interesting facts concerning this letter:

1. 52,000,000 copies cost the tax payer \$107,500.
2. 12,000,000 were printed by the Government Printing Office. 40,000,000 were farmed out to job printers.
3. \$107,500 represents the Federal income tax paid by 725 wage earners who make \$3,500 a year and support a wife and two children.
4. The letter was unnecessary because also en-

closed with the tax forms was a 12 page pamphlet entitled, "How to Prepare Your U. S. Income Tax for 1951."

Mr. Truman is as confused as you and I are.

Press conference Dec. 18, 1946: Mr. Truman was asked if he were urging the Nationalist Government of China to accept Communists in the Cabinet. He replied this had been set out in his statement on China. It has, he added, been our policy all along.

Press conference March 11, 1948: President Truman was asked again if it is "still the policy of this government to include Chinese Communists in the Chinese government." Truman said he didn't know that was ever the policy of the government and added, if it was it was news to him.

The difference between war and a police action.

Korean casualties from June 25, 1950 to Jan. 1, 1952 (18 months) 105,000.

World War II Pacific area casualties from Dec. 7, 1941 to Nov. 1, 1943 (23 months) 65,405.

In 1943 military victory was in sight.

February 11, 1952

National Defense Secretary Robert A. Lovett appeared before the armed services subcommittee of the Appropriations Committee Feb. 4th. He presented the 52 billion dollar budget for 1952-53 fiscal year which is supposed to take care of our defense in case more police actions break out.

Senator Homer Ferguson of Michigan asked the Secretary how much the Korean war had cost the taxpayers so far, to which Mr. Lovett replied that they hadn't been able to estimate it yet.

Senator Ferguson put another question to the Secretary: If you can't estimate a war which has been going on for the last 19 months, how can you hope to estimate the cost of a war which hasn't even started.

Chairman of the subcommittee, Senator Joseph C. O'Mahoney of Wyoming decided to adjourn.

A friend in a high place.

There will be a senatorial investigation into the 1,800 pardoned criminals President Truman has been responsible for since he has been in office. If you write to Mr. Daniel M. Lyons, pardon attorney for the Justice Department, he will tell you that there have been 5,000 criminal pardons in the past 18 years, but he will also tell you that all names and information are secret.

What your children learn in school.

Some exceptionally startling testimony in the McCarran hearings on the Institute of Pacific Relations (IPR) can be found in volume 4, pages 957 to 963. This testimony reveals that the IPR published pamphlet textbooks which were used in our schools. This branch of the Institute was in charge of Marguerite Stewart. The counsel for the committee mentioned the fact that Marguerite Stewart is the wife of Maxwell S. Stewart. Maxwell S. Stewart, he said, had been named in previous testimony as being a member of the Communist Party. Excerpts from one of these pamphlets used in our

schools as read to the committee showed Russia in a most favorable light.

February 18, 1952

Political expediency vs. U. S. honor.

The big stumbling block in the truce talks is the exchange of prisoners. The American forces have been dropping leaflets over enemy lines offering complete protection to any Red soldiers who surrendered. Thousands have poured across no-man's land bearing the leaflets. Some, relying on the American promise had the letters "U. N." tattooed on their arms while in camp.

Last week Dean Acheson and Gen. Omar Bradley briefed the Senate Armed Services Committee on the progress of the cease-fire talks. Some Senators gathered that we were willing to give up the prisoners who did not want to return, in spite of our pledges to them.

Sen. Jenner of Indiana, prepared a resolution declaring that it was the "sense of the Senate" that prisoners who did not want to return to their homeland should not be forced to; 25 senators endorsed the resolution. When word leaked to the Pentagon, Secretary of Defense Robert Lovett and Gen. Bradley immediately contacted influential Republicans warning them that such a resolution would interfere with the truce talks.

The Senators became alarmed that in an election year they might be called "warmongers," and a majority of the signers withdrew their names.

If these prisoners who trusted our leaflets promising security are returned to the enemy, the word will spread, and never again will enemy soldiers wishing to desert the Red forces trust the word of the United States government.

You haven't paid anything yet:

In case of an all-out war with Russia the estimated cost is one trillion, five hundred and seventy-five billion dollars. That is more than 30 times the \$52 billion defense budget for the coming fiscal year. It would mean that your taxes would be about 20 times more than you will pay next year.

And in case you are worried.

The army purchased enough spare parts for jeeps to last 104 years.

Quote of the week.

We are closer to peace now than we have been in the last five years.

HARRY S. TRUMAN, June 1, 1950

February 25, 1952

How to waste money and make the U. S. look silly too.

The State Department has presented Congress with a \$170 million budget for the Voice of America. The radio log of "The Voice" for January and February of this year shows the following broadcasts:

To Japan: "Feature, Jan. 22, 4:30 to 5—Children and TV." In the whole of Japan there is not a single television station or set.

To Germany and Russia: "Jan. 29—The Supreme Court decision on Judy Coplan." This was broadcast for "breakfast" and evening.

To England: "Feb. 5, 8 to 8:30—American housewives discuss pie baking." British housewives do not have the necessary sugar to bake pies.

To Arabia: "Jan. 12, 2 to 2:30—Happiness and marriage." Arabian girls marry at a tender age and their husbands may have four wives. According to Koran law a man divorces a wife by rejecting her three times before witnesses.

To Korea: "Jan. 19, 5:30 to 6—U. S. in Review, The snowbound train in the Sierras." The uncom-

fortable plight of the passengers could hardly have aroused sympathy from the war torn Koreans.

To Italy: "Jan. 14, 12:15 to 12:30—Weather forecast for N. Y. in 1952."

From the Cover of the Book, "Solution in Asia" by Owen Lattimore:

"He shows that all the Asiatic peoples are more interested in actual democratic practices, such as the ones they can see in action across the Russian border, than they are in the fine theories of the Anglo-Saxon democracies which come coupled with ruthless imperialism . . . He inclines to support the American newspapermen who report that the only real democracy in China is found in the Communist areas."

Where go the planes?

From Time, Feb. 4, 1952: Assistant Secretary of the Navy for Air, Jack Floberg said, "The situation is so bad that the Navy has 1000 planes fewer than it did 20 months ago when the Korean war began."

Quote of the week.

The people of every country are the only safe guardians of their own rights and are the only instruments which can be used for their destruction.

THOMAS JEFFERSON

CANCER SECTION OF THE BALTIMORE CITY MEDICAL SOCIETY NEWLY ESTABLISHED

At a meeting of the Baltimore City Medical Society on Friday, April 18, 1952, the formation and official recognition of a Cancer Section was ratified. The purpose of this Cancer Section will be to facilitate an exchange of ideas as freely as possible. Interested clinicians and investigators from the University of Maryland Hospital and School of Medicine, The Johns Hopkins Hospital and School of Medicine, the U. S. Public Health Service Hospital and the National Cancer Institute have held several seminars this year to initiate the local cross-fertilization of information in the field of cancer. Members of the Baltimore City Medical Society sponsoring this new Cancer Section are as follows:

Dr. Jacob Colsky	Dr. Arthur G. Siwinski
Dr. Louis E. Goodman	Dr. Edwin H. Stewart, Jr.
Dr. David M. Gould	Dr. George A. Stewart
Dr. Mitchell H. Miller	Dr. Grant E. Ward

Dr. Edward F. Lewison was elected Chairman and Dr. Robert Cooley was elected Secretary of the Cancer Section.

The next meeting is to be held at the National Institute of Health, Bethesda, Maryland, and the program is being arranged by Dr. John R. Heller, Director of the National Cancer Institute. The date and program will be announced later.

Scientific Papers

PANEL DISCUSSION: THYROID¹

The Baltimore City Medical Society held a Panel Discussion on Thyroid, on Friday, January 18, 1952, at 8:30 p.m., at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland, with Dr. Samuel McLanahan, President, presiding and Dr. Edward Rose as Moderator.

EDWARD ROSE, M.D.,² *Moderator*

Disorders of the thyroid gland are of particular interest and importance to physicians in a number of areas of medical practice. These disorders are of concern to the internist, to the surgeon, to the clinical pathologist, to the pediatrician, to the endocrinologist, to the neuropsychiatrist, and last but certainly by no means least, they are of paramount importance to the general practitioner. The general practitioner and perhaps the pediatrician, I think, occupy the front line positions in the recognition of incipient, larval and atypical thyroid disease. The ultimate fate of the patient usually rests as much upon their diagnostic acumen and judgment as upon the skill of the specialist who may subsequently take charge of the therapeutic problem.

The interest in our study of thyroid disease, in our diagnosis of thyroid disorders and in our ability to treat these disorders, has been tremendously enhanced within the past decade as a result of the development and utilization of several new materials and techniques. These include, of course, the preparation in relatively pure form of thyrotropic hormone of the anterior pituitary; the development of methods for the accurate

measurement of the hormonal iodine fraction of serum, and looming large among these new methods and materials is the use of radioactive isotopes of iodine for diagnosis and treatment and development of a considerable number of so-called antithyroid compounds. As a result of these advances, we are now in a much better position to study thyroid function, to recognize atypical forms of thyroid disease, and treat the patient, than we were a decade ago. We are now almost in a position where, in many instances, we can offer the patient a choice of treatment. We can more or less tailor the treatment to fit the individual need of the patient, a state of affairs that did not exist up to ten years ago. In the past, when treating a patient with a toxic goiter we were limited to two or three procedural methods. We could either prepare for surgery hoping we would be able to prepare him safely; we could resort to external irradiation or we could fall back on the time-honored but highly ineffective method of giving stable iodine intermittently and hope the disease would eventually burn itself out.

Today the story is entirely different. Your Program Committee has selected a group of gentlemen for this panel discussion, all of whom are interested in and experienced in various phases of the problem of thyroid disease. I hope that I shall be able to function here as a kind of

¹ Presented before the Baltimore City Medical Society, Friday, January 18, 1952.

² Associate Professor of Internal Medicine and Chief of Endocrine Section, University of Pennsylvania Hospital, Philadelphia, Pennsylvania.

Clifton Fadiman before this "Information Please" group, and to try to keep the ball of discussion in the air, or keep the pot boiling so to speak. I hope questions will be liberally forthcoming from the audience and I certainly trust the entire atmosphere of the evening will be highly informal. There will be plenty of give and take and no one will hesitate to say exactly

what he thinks as long as it is printable and recordable.

In order to start the pot boiling, each member of the panel has been asked to present and discuss briefly a couple questions. I hope all of you gentlemen have your questions ready. First, I will ask Dr. Dixon if he will answer two questions.

PSYCHIATRY

WILLIAM T. DIXON, M.D.

Q. What psychic and emotional disorders most frequently simulate thyrotoxicosis?

In other words, what purely psychogenic disorders make it difficult to make a diagnosis of true thyrotoxicosis? I think that the most common of the disorders would be a psychoneurotic reaction of an anxiety type. This simulates in many ways nearly always a true thyrotoxicosis. To mention some of the similarities, there are tachycardia, increased sweating, weight loss, diarrhea, tremor, choking sensations, shortness of breath which is referred to as "globus hystericus" in old fashioned psychiatric terms. There is often a slight elevation in blood pressure. There may be vomiting and clinical findings such as very mild glycosuria. In addition, there may be an elevation of the basal metabolic rate. All these things may be found in anxiety neurosis and of course, all of them can be found in thyrotoxicosis.

The second type of psychogenic reaction, would be a depression. Very often, particularly in middle aged or elderly women, the elements of depression make it very difficult to decide whether you are dealing with thyroid disease or a purely psychogenic reaction. The insomnia, weight loss and agitation, ceaseless restless muscular activity and the attitude of depression make it a difficult diagnostic problem at times.

Another type of reaction is the hypomanic re-

action—in other words, excitement due to a mood of elation. Some people are referred to as "a hyperthyroid personality" meaning an energetic personality which, in an extreme form would lead to complaints by the patient and others around them.

Q. With what patterns of psychic aberration are thyrotoxicosis and myxedema most often associated?

In other words, when you have a given case of thyroid disease, what type of psychogenic disorder is most frequently present?

I would again say the one that is most frequently present is the psychoneurotic reaction with symptoms of marked anxiety, phobias and hysterical symptoms. There may be an associated psychotic reaction such as a manic depressive reaction. How to separate them sometimes is quite a problem. Which is thyroid disease and which is emotional illness. They are so bound up that I don't think you can separate them.

There may be a paranoid psychotic reaction where the patient is deluded, suspicious, thinks people are trying to persecute him, and finally there is a delirious type of reaction which is called a toxic delirium or delirium due to lack of support of the brain.

In myxedema I do not have as much information, but generally psychotic reactions are more prevalent when the patient is emotionally upset

and sometimes there are neurasthenic reactions—that is psychoneurotic reactions. The old term neurasthenia is associated with weakness, coldness of extremities and fatigue.

DR. ROSE: Thank you, Dr. Dixon. We are all very familiar with the occasionally very difficult problem of differential diagnosis which is posed by the highly emotional patient, the patient with symptoms which could be due either to psychic or emotional disease, or which might be the early manifestation or the atypical masking phenomena of thyrotoxicosis. Fortunately, some of the newer diagnostic methods which are now available and which I hope will be discussed with more detail this evening, come in as very

useful tools in helping us solve these occasionally very difficult problems. Several patients whom I have seen in the late, terminal stages of manic depressive psychosis, have gone into a terminal episode which has closely simulated the clinical picture of the thyroid storm or crisis. I'd like to know whether that similarity has struck you, Dr. Dixon?

DR. DIXON: Yes, I have seen it. I don't know whether they have been studied for endocrine disturbances. I suppose they have but I don't know the findings.

DR. ROSE: Thank you, Dr. Dixon. I'd like to ask Dr. Rienhoff if he will continue the discussion.

SURGERY

WILLIAM F. RIENHOFF, JR., M.D.

In answer to Dr. Rose's question I would like to say that we surgeons feel that the use of propylthiouracil combined with Lugol's solution is an excellent method of preparing patients for the surgical treatment of hyperthyroidism. I am not convinced that the use of this drug, namely, propylthiouracil should be used as a definitive measure. Some patients will improve for two years or so and then begin to escape the influence of this drug. Certainly for the average, run of the mill case of hyperthyroidism, particularly with a fairly large thyroid gland, we feel that the operative treatment is more permanent and more satisfactory for the length of time the patient must be under the guidance of a physician and a surgeon.

There are, of course, individuals who cannot take propylthiouracil, in fact, any thyroid drugs. Another objection is that patients become rebellious against the constant laboratory supervision and the necessity for always taking a drug day in and day out.

There are certain patients for whom thyroid-

ectomy is contraindicated, and for these the medicinal treatment with propylthiouracil is certainly a boon; namely, in acute hyperthyroidism following an upper respiratory infection; in the latter stages of pregnancy; in elderly patients; in hypertension associated with cardiac failure, and for patients who refuse operation.

I do not believe that once a thyroid gland has undergone hypertrophy and hyperplasia it will ever revert to the normal histological picture or the gross size of the gland when treated with propylthiouracil. People living in parts of the state or states that are inaccessible to proper laboratories have great difficulty in checking their blood counts and their metabolic rates. Furthermore, there is always the personal element of stupidity or carelessness in adhering commendably to a medical regime.

In regard to nodules in the thyroid gland, I am firmly convinced that all solitary nodules should be removed and carefully examined histologically. The instance of malignancy in these nodules varies from 15 to 25 per cent, depend-

ing on the individual clinical records. These nodules may or may not be malignant from the beginning. The danger of malignant change in multiple nodular goiters is certainly less than in the solitary nodules.

The type of operation to be done depends upon the type of tumor. The intracystic papillary adenocarcinomas, of course, are very slow-growing and metastasize only to the lymph nodes; therefore, the glands should be removed with the thyroid, bilaterally. The malignant adenoma, however, does not spread by the lymph stream and it is necessary to remove only a portion of a lobe, and not a radical lymph node dissection of the neck.

In regard to cardiac arrhythmias associated with multiple nodular goiters, I feel that the thyroid should be removed before the arrhythmia has been in existence.

Q. DR. ROSE: What about the second question, Dr. Rienhoff, the needle biopsy?

DR. RIENHOFF: Oh, yes. I forgot that one. I can only remember needle biopsy to condemn it. In the first place the thyroid gland, as all surgeons know, is a gland in a state of flux. It is a gland that presents a different histological picture on either side. Whenever you put a needle in the thyroid gland, you do not know whether or not you're going to put it in a large vein; you don't know that the biopsy specimen you get through a needle is going to be representative of the gland as a whole. I feel that if I were the patient, I'd much rather have the surgeon explore my neck and see what he's got before him, rather than do a needle biopsy. Biopsy might not be representative of the pathological picture of the gland as a whole. I am against needle biopsies; if it is carcinoma it may be spread through the needle puncture, as has been done in lungs; or if you happen to hit an area that is benign, how in the world can you tell what exists in the remainder of the gland, particularly intracystic papillary adenocarcinomas.

Dr. Firor, sitting back there, was talking the other day at a conference, saying that sometimes

one sees glands in the neck or the patients feel them. You remove one of these glands, you look at it in the gross, and you can be pretty sure that it isn't a lymph gland. It looks like thyroid tissue so therefore you know in all probability, and particularly with the information of the frozen section, that there is a tumor in that lobe probably on that side. Now I feel very strongly about this situation. I think you should do a double partial lobectomy, a removal of both lobes, because we have seen that these tumors will occur bilaterally. Dr. Blalock had that experience, and I've had it three times. Dr. John Pemberton, at the Mayo Clinic, found that you often have a small tumor not any larger than a small pea, which will metastasize in the gland and will be quite large (two centimeters by one and a half centimeters) so I feel that if you did a biopsy and happened to hit the normal part of that lobe, you'd say, therefore, Dr. Rose, that this is not malignant. You would be misled; and I don't like needle biopsies anyway.

DR. ROSE: The chief proponent of needle biopsy of the thyroid at present seems to be Dr. George Crile, Jr., of the Cleveland Clinic. I believe that he considers it tremendously useful in detecting certain types of chronic thyroiditis, in which surgical treatment is either not indicated or only a conservative partial measure late in the disease in such types of thyroiditis as the struma lymphomatosa or the Hashimoto goiter. I know that a number of other thyroid surgeons do not share Dr. Crile's enthusiasm for this procedure. I have discussed it recently with Dr. Ravdin and I think he substantially shares your own views, Dr. Rienhoff. The problem of multinodular goiter is an extremely knotty one as I am sure you all realize from what Dr. Rienhoff said. Even the problem of the so-called solitary nodule is not always so simple because I think we must bear in mind constantly that the portion of the thyroid gland that one may see or feel does not by any means always indicate the true size, location and shape of the entire thyroid gland. Frequently we think we are dealing with

a solitary nodule and when the gland is exposed to view by the surgeon, frequently a number of other nodules are found hidden away beyond the reach of the palpating finger.

One of the difficult questions is, when is a solitary nodule really a solitary nodule? Various arguments have been advanced in recent years in support of the idea that the multinodular nontoxic goiter should be treated conservatively. The arguments have included the statement that the incidence of carcinoma in the multinodular goiter is so low that the operative risk of removing the goiter is greater than the risk of malignancy if you leave it alone. Such a statement

seems to reflect a little bit on the surgical mortality of the institutions which had been used in the collection of statistics. Other claims are to the effect that if you operate on a multinodular goiter you have either got to do a total thyroidectomy or nothing at all; if you do a subtotal thyroidectomy you may leave behind certain microscopic foci from which regenerative changes may lead to the development of new adenomata and possibly carcinoma may develop when none was present at the time of the original operation. These are some of the controversial points that are tremendously difficult to settle.

DR. ROSE: Dr. Carey, would you present your question please?

INTERNAL MEDICINE

T. NELSON CAREY, M.D.

Q. For his first question Dr. Rose asks me what are the indications for the use of stable iodine in the prevention and treatment of thyroid disorders.

The most fundamental use of stable iodine in thyroid disease is for the prevention of endemic goiter, which we do not see in this part of the country. The basic research on this problem was done thirty years ago or more, and you will remember that it refers to the prophylaxis, in the mass of the population, of the thyroid enlargement that appears so frequently in the "goiter belt" or glacial parts of the United States, in the Alps, and in mountainous districts elsewhere in the world.

It is interesting to all of us that the dose of iodine used for this purpose is almost fantastically small, somewhere between 70 and 150 micrograms daily. This may be supplied by the routine use of iodized salt containing less than one part of sodium iodide per 5,000 parts of sodium chloride.

In the treatment of endemic goiter once it has

developed, larger doses are necessary, but they are still amazingly small. It has been suggested that one milligram of potassium iodide weekly, in addition to the prophylactic dose, may be entirely satisfactory, if the goiter is reversible and has not passed the period of hyperplasia which can be returned to normal by the use of iodine. There are other variants of this type of goiter. One of them was discovered in Dr. Chesney's laboratory some twenty-five years ago. Rabbits that were fed on a cabbage diet developed thyroid enlargement, and the term "cabbage goiter" has been applied to this phenomenon. Some human cases have been described. As the disease is caused by relative iodine deficiency, it may be prevented or treated by increasing the iodine intake.

More recently, stable iodine has become very important in the prevention of the hyperplasia and bleeding tendency caused by the antithyroid drugs. When the antithyroid drugs were first introduced, iodine was only given during the last week or ten days of preparation for opera-

tion, but later on it was discovered that iodine could be used at the onset of antithyroid drug therapy. The surgeons found that glands treated in this manner were much less frequently a source of bleeding and that hyperplasia was far less troublesome.

The next use of stable iodine that we should discuss is the standard method of production of the iodine remission in hyperthyroidism. This method of preparation for operation is still used at times. The dose of iodine necessary to cause remission was studied many years ago, particularly by Means and his group. Again, the dose is quite small, and where we are all accustomed to giving twenty or thirty drops of Lugol's solution or solution of potassium iodide daily to cause the preoperative remission of hyperthyroidism, it has been convincingly demonstrated that only six milligrams of iodine is actually necessary. According to Dr. Mean's calculations, this represents only one drop of Lugol's solution daily. Actually, however, since iodine is not expensive and since there is no reason for stinginess in dosage, I believe that no one limits himself to this small quantity.

The next important use of stable iodine is in the emergency management of the unexpected crisis. Postoperative thyroid storm has almost completely disappeared, but occasionally because of unjustified use of iodine in toxic goiter and its sudden withdrawal, crises may appear. The critical patient is entirely too ill to depend on the relatively slow action of the antithyroid drugs or radioactive iodine, though he can, under certain conditions, be helped very dramatically by the administration of stable iodine in large quantities by whatever method it can be given, along with other therapeutic measures, such as sedatives, oxygen, and fluids.

This is an extremely short and, I hope, not oversimplified description of the uses of stable iodine in the management of thyroid disease generally. I am quite sure that I have neglected some important facets of the problem, and I hope that I will be forgiven if I have done so.

Q. The next question is far more difficult to answer, and I do not believe that it has ever been satisfactorily solved. Dr. Rose asks me to discuss the optimal therapeutic program for the hyperophthalmopathic syndrome.

The patient with this problem has, in addition to moderate or marked exophthalmous, stare, lid lag and the other eye signs associated with hyperthyroidism, excessive lacrymation, burning and stinging of the eyes, edema of the conjunctivae, and occasionally, inability to close the eyes completely. It is interesting that the clinical picture is as often seen in the mildly hyperthyroid individual, as it is in the patient with severe toxic goiter.

Treatment of this complication should be based chiefly on the principle of not making it worse. It is known that overtreatment of hyperthyroidism can lead to further production of the thyrotropic pituitary hormone with further exaggeration of exophthalmos. The rule should be, I suppose, that thyroidectomy should be undertaken with the greatest of caution, whether that thyroidectomy is surgical with the knife, medical with the antithyroid drugs, or radioactive with I^{131} . Much work has been done on the problem, and some investigators believe that the prolonged conservative treatment with rest and sedatives may be the method of choice, hoping that the hyperthyroidism may subside without the exophthalmos becoming more troublesome.

Other methods have been tried. Thyroid has been administered when basal metabolic rate is not too much elevated, or when progressive exophthalmos appears postoperatively, in an effort to suppress the production of the thyrotropic hormone. Radiation of the orbits, radiation of the pituitary gland, and more recently adrenocorticotrophic hormone have been tried. None of these measures have proven to be satisfactory. The last resort is surgical decompression of the orbits, either by the frontal approach of the Naffziger operation or the more recently devised temporal method. Surgical intervention is usually reserved for those individuals whose sight is in

danger and is not recommended for cosmetic reasons.

DR. ROSE: Thank you, Dr. Carey. I see so constantly so many glaring examples of the misuse and abuse of stable iodine, especially in the treatment of thyrotoxicosis, that I was constrained to submit this question to Dr. Carey. I think it is an extremely important point. In spite of the constant factual reiteration to the medical profession that stable iodine almost always exerts only a partially ameliorating effect upon thyrotoxicosis, and that usually the effect is temporary and that after several weeks or a couple of months the patient will become iodine resistant and just as toxic and even more toxic than he was when the treatment was started, we still see numerous examples of the misuse of iodine. It isn't so much of a tragedy as it was ten or twelve years ago because we have at our disposition all the antithyroid drugs with which we can almost always bring a patient into satisfactory remission, but it is still a sore point with me in practical therapeutics.

We happen to have in our hospital at the present time, a delightful young woman, wife of a physician, who developed thyrotoxicosis last summer and whose sole treatment until she was brought to our hospital on the verge of a thyroid storm consisted of the administration of Lugol's solution by her husband. She had had no studies and that was her only therapy.

The second question which Dr. Carey answered is, as he says, a very difficult one and it was with some apology in my mind that I submitted it. Therapy of the so-called hyperophthalmopathic syndrome is almost impossible to evaluate. These patients look as though they are going to lose their eyesight; they look as though their eyeballs are going to bulge out from their cheeks, which occasionally they do. Yet even in their most formidable stage where catastrophe seems inevitable, the whole process may cease spontaneously and the acute congestive and inflammatory phenomena may begin to re-

cede. The patient may regain practically normal vision after being almost blind. This can happen spontaneously and when it does happen after one or a number of therapeutic agents have been employed, it is obvious we are in no position to draw conclusions regarding the effectiveness of our treatment.

I might mention the recent enthusiastic reports that arrived in this country from France about a year ago concerning the alleged inhibitory action of a compound called para-hydroxy-propionophenone upon certain hormonal production of the anterior pituitary. This substance which in essence when you look upon its structural formula, looks about like one half diethylstilbestrol molecule, was claimed by French physiologists and clinicians to be capable of inhibiting the thyrotropic and gonadotropic hormones of the anterior pituitary without affecting the adrenocorticotrophic output. These claims, if true, would have been sensational and therapeutically revolutionary and a lot of people over here immediately got busy in an effort to support the French claims. The French reported several hundred patients with thyrotoxicosis with and without associated ophthalmopathic phenomena having been treated very successfully, and patients with various disturbances associated with increased output of gonadotropins also having been treated successfully.

The experiences both in the laboratory and in the clinic in this country with this compound as far as I have been able to learn, including our own clinical use of the drug, have been almost completely disappointing. We have treated a number of patients with hypothyroidism, ophthalmopathy, diabetes, some patients with menopause and menopausal syndrome, and we have not seen any real evidence that it has been or has produced any effect other than that which might have been due to suggestion to the patient.

Would you present your questions please, Dr. Berthrong?

PATHOLOGY

MORGAN BERTHRONG, M.D.

Q. The first question is: What is a Hürthle cell? I might say at the beginning that it is unfortunate that we have such a name in the pathological literature. In the first place it is a misnomer. Hürthle originally described a large eosinophilic cell in the interstitial tissues of the thyroid gland of a puppy dog. Whether or not these same cells ever occur in humans is still a question. Furthermore, these cells were described in the human thyroid years before Hürthle made his observations in the dog.

In any case, the so-called "Hürthle" cell is a large eosinophilic cell which occurs in the thyroid in a large number of abnormal conditions. It seems to be quite nonspecific. It may occur in neoplasms or non-neoplastic diseases. In the former it may constitute the sole neoplastic cell; at other times only a portion of the neoplasm is made up of these cells. The Hürthle cell is quite commonly seen in non-neoplastic thyroid diseases and is especially prominent in Hashimoto's struma. They are also seen in Riedel's struma but far less prominently. They were described very early as a prominent cellular change in hyperplastic thyroids. I think I can summarize by saying that the Hürthle cell probably represents a metaplastic change of normal thyroid epithelium during a wide variety of disorders of the thyroid. Hürthle cells are not specifically related to any functional change, as far as I know. I would like to add that similar cellular changes occur in many other organs as in the salivary glands, mucous glands of the upper respiratory tract, in the gall bladder, and others.

My second question was somewhat introduced by Dr. Rienhoff who suggested that I might talk about thyroid cancer, nodular goiter, solitary nodule, etc. He reminds me of my brother who used to lead me up on the top of the high diving board and I'd look down from the end of the board at the water a mile below, and he'd say "jump, you coward, jump!" I'm not going to

take that bait entirely, but the question that I do have is:

Q. What proportion of nodular goiters represent true adenomas?

I don't know the exact figures but I am certain, Dr. Rose, that of all the nodules that occur in the thyroid glands of people both in endemic and non-endemic area, both macroscopic—that is palpable nodules,—as well as microscopic nodules, that the vast majority are not true neoplasms. They probably represent some result of abnormal function which, throughout the years at different levels of physiological activities with alternate periods of hyperplasia and involution, has led to the development of nodular masses in the thyroid. True adenomas are certainly very rare in comparison to these non-neoplastic nodules.

Finally, Dr. Rose, you have asked me what the relationship is between true adenomas and thyroid cancer?

My first words will be that I don't know. Second, I don't think it is clearly known anywhere. We have many references which give figures of eighty to eighty-five per cent of all cancer in the thyroid arising in benign adenomas. In our own end of the scale we had fifty-five carcinomas of the thyroid in a period of ten years, one of which a pathologist suggested probably arose in an adenoma. The problem for pathologists to say that a benign adenoma was originally benign and became malignant, or was always malignant, is so great that there can be no clear-cut answer to this question. The very long clinical duration of this type of thyroid cancer greatly complicates our precise understanding of the question. We see adenomas of the thyroid which have in every way a histological appearance which is utterly benign and yet we have metastasis in the bone, lung, etc. On the other hand, we see nodules in the thyroid which appear histologically malignant that had

no evidence over a period of many years of any clinical malignancy. Some may show metastasis after 20 or 25 years while others with the same histological appearance may pursue a far more rapid course. It does seem probable that given a patient with a solitary nodule in the thyroid, especially in children, young adults or men, the pathological examination is much more apt to show a true tumor, either an apparently benign adenoma, an adenoma with evidence of early malignant changes, or an overt cancer, than is the case if diffusely nodular glands are so examined.

DR. ROSE: I submitted a question about the Hürthle cell because many of you gentlemen are going to receive from time to time reports from the pathologists describing the histological appearance of thyroid tissue removed from some of your patients, in which this term protocell will appear. As Dr. Berthrong pointed out, the nature of the cell, and function, if any, is controversial. I think the majority of opinion at the present time inclines to the view it does not represent a specific cell type in the thyroid, but may represent a transitory functional phase of several types of cell which take on the characteristic eosinophilic strain and which may be found under different circumstances and in different parts of the thyroid structural units.

I submitted the second question because this whole problem of being conscious of the premalignant lesion in the thyroid is an extremely important one. All of us who work in thyroid clinics are constantly encountering examples of neglected thyroid cancer in which life could have been saved by the exercise of good clinical judgment at some time in the patient's past history.

Q. DR. RIENHOFF, you did some pioneer work some twenty-five years or so ago on the pathogenesis of thyroid nodules and the incidence of true adenomas and so-called colloid hyperinvoluted nodules in goiter. Would you care to comment on anything Dr. Berthrong said?

DR. RIENHOFF: A number of years ago when Dr. Arthur Bloomfield was here and after Dr. Plummer brought in the iodine treatment, I

think it was in 1922 or 1923, we found there were artificial remissions due to the administration of Lugol's solution and with the permission of Dr. Finney, Sr., I biopsied the thyroid gland before and after giving iodine. We found even in the artificial iodine remission, there were areas which underwent hyperinvolvement which not only returned approximately to the normal status of the normal gland but overdid it. It was somewhat like an emphysematous lung. Follicles would dilate and form large cysts through the gland and some areas would show localized hyperplasia, which Dr. McCallum first called attention to, and which would persist. These could even be palpated in the gross. Now the question is what is the character of these nodules. We have often seen the step-up goiter of pregnancy following the physiological hypertrophies and hyperplasias due to pregnancy, and undergoing involution.

People in goiter districts in which for some reason or other these processes such as hypertrophies and hyperplasias as well as involution are exaggerated may appear with nodular goiters. They can even tell you "this nodule appeared after such and such a child was born." They are usually in the mountainous districts. We decided that very few of the nodules really—and that was with fairly good pathological supervision, could be considered benign tumors; that most of them were coals of the fire that had burned and they were probably physiological residues. I was very much interested in a discussion Dr. Trimble made the other day. He stated that if you are going to remove the lobe of a gland because of multiple nodules, where are you going to stop because you will probably find they are multinodular glands. Nodules will be found not only in one lobe but you will find them in others probably. It is a very controversial question; are you really operating on neoplasm or multiple neoplasia, or are you operating on physiological residues?

DR. ROSE: Dr. Asper has a couple questions which are quite active and of current interest.

RADIOACTIVE IODINE

SAMUEL P. ASPER, JR., M.D.

Radioactive iodine is assuming a role in the diagnosis and therapy of certain thyroid disorders and is still in a process of development. So far, it probably has reached its highest development as a tracer test or a diagnostic test for the determination of the state of function of the thyroid gland. I am sure that the next few years will see considerable revision in this procedure which will make it available for use in most all clinics. One must remember, however, that the test as now used measures only the thyroid's avidity for iodine and does not therefore reflect the rate of function of the thyroid gland. Like the BMR, it does not give an exact interpretation of thyroid function. It is therefore not only dependent on the activity of the thyroid gland and the rate at which thyroid hormone is formed but also on the supply of iodine which the patient has been receiving.

The radioiodine tracer test has considerable clinical value chiefly because of its accuracy. Probably it is best used in rather difficult thyroid cases. In patients Dr. Dixon described, having psychiatric abnormalities and in whom the diagnosis of hyperthyroidism is questioned, the administration of a tracer dose of radioiodine oftentimes will establish whether or not the thyroid gland is hyperfunctioning. In such patients the basal metabolic rate would not be feasible. It does not supplant the basal metabolic rate nor does it supplant the protein bound iodine determination.

One must also remember that radioiodine tracer tests have no value in patients who have received large doses of iodine in any form. A patient who has received Lugol's solution prior to coming to the laboratory for a radioiodine tracer test will have no accumulation of the radioactivity in the thyroid gland because of the previous saturation of the body with excess iodine. The same is true for iodine administered as an x-ray dye or for some vitamin preparations which now

also include iodine. Also desiccated thyroid or thiouracil and other antithyroid drugs, will affect the test during their administration. It is necessary, therefore, to remove the patient from desiccated thyroid or thiouracil or the iodine preparation for a considerable period before the radioiodine tracer test is of clinical value.

When it comes to selecting patients for therapy with radioactive iodine, which is the second part of the question Dr. Rose submitted, we are at the present time in a state of flux. In our clinic patients who are treated with radioactive iodine are patients not suitable for other standard forms of treatment, and in general they are complicated thyroid cases. But it is most amazing to us that, despite the fact these patients have complicated disease, the results are exceptionally good. It may be with further experience that radioiodine will be used more extensively. It already is used in some clinics for the treatment of Graves' Disease. In these patients, the radioactive iodine is given by mouth. The difficult part of the therapy is to calculate the dose; generally, it is between five and ten millicuries. It is repeated after two or three months if hyperthyroidism still persists, usually at a somewhat smaller dose. It may be necessary in some patients, especially those with nodular goiter, to give several doses before the disease is ameliorated.

It has its especial advantages in older patients who are not suitable candidates for surgery. The most suitable example for the use of radioiodine that one could hope for occurred recently in a patient who came to the hospital with severe hyperthyroidism. She was elderly and had auricular fibrillation and cardiac failure. She had been sensitive to propylthiouracil, thiouracil and Lugol's solution. She was too sick to consider subtotal thyroidectomy. She received radioactive iodine and had a complete recovery. One might ask, "Why could she take radioactive iodine and

not have a reaction when she had been sensitive to Lugol's solution?" The amount of iodine contained in a therapeutic dose of radioactive iodine is an infinitesimal amount of iodine, and would be equivalent to the amount occurring in about a teaspoonful of Baltimore tap water. Knowing that she was not sensitive to the iodine contained in tap water, one could give her without hesitation radioactive iodine.

DR. ROSE: Thank you, Dr. Asper. The final mapping of the usefulness, limitations, possible dangers and undesirable or late sequelae of radioactive iodine will certainly not be completed for a number of years. I think there can be no doubt

that it offers us a very powerful therapeutic weapon, but it will take some time before we are in a position to use it with complete intelligence. Until that time comes I think it should properly be looked upon as a method of treatment still in an exploratory phase. Its use is as a therapeutic agent in the treatment of thyrotoxicosis in children or with certain occasional exceptions in young adults; we avoid its use in pregnant women and are attempting insofar as we can to limit it to middle aged or elderly patients.

Now we have several questions from the audience and I'm going to ask Dr. Fort if he will read them.

QUESTION AND ANSWER PERIOD

Q. Please give a clear-cut statement on the indications for the use of thyroid extract and a practical method for control of the dose?

DR. ROSE: I think this is a very important question because along with stable iodine (in the form of Lugol's solution), potassium iodide and other pharmacopeial preparations, desiccated thyroid is one of the most misused and abused drugs in the entire United States. I'm going to ask Dr. Carey if he will undertake to answer that question.

DR. CAREY: I certainly agree with Dr. Rose in his statement that thyroid is misused many, many times, and I believe that its chief misuse is in the attempted reduction of obesity. You will remember that the obese person has excess heat production to start with. This is a wonderful safety factor that the body has developed to keep us all from becoming tremendously obese. As weight gain appears the basal metabolic rate rises. If this were not so, with a little bit of extra food every day any individual would in a relatively short time become tremendously obese. Therefore, it is sensible to believe that if the obese person has an elevated basal metabolic rate to start with, administration of thyroid by

mouth is not the proper method of reducing weight. The proper method to reduce weight is, of course, by diet, and by diet we should mean undernutrition for the person's ideal weight. This method, if carried out, predicts weight reduction most accurately. Many times the emaciated person will be given thyroid because the basal metabolic rate is low. There again, is an example of the same principle. As the body loses weight the basal metabolic rate falls, heat production declines as a safety factor, and the body protects itself from wasting away altogether. Along with weight loss, basal metabolic rate falls, vital functions also are preserved, sexual potency disappears, menstruation stops, and gynecomastia develops in the male. This was all demonstrated very vividly in prison camps during the recent war. Therefore, it is sensible to believe that a starved person whose basal metabolic rate is as low as minus 25 per cent certainly does not require thyroid to gain weight, but simply requires food. I believe that these are the two most glaring examples of the misuse of desiccated thyroid. Proper use, of course, is in true thyroid deficiency which is most commonly seen after operation for hyperthyroidism or total thyroidectomy either

intentional or unintentional. In that case we have a true state of myxedema which requires a surprisingly small amount of desiccated thyroid for correction. It is important to remember that the myxedematous person is quite sensitive to this material, and that the average patient requires about 100 milligrams daily, about one and one-half grains. A larger dose is very commonly associated with toxic symptoms. The drug should be used carefully with guiding estimations of weight, heart rate, basal metabolic rate, blood cholesterol estimation, and observation of response of symptomatology.

DR. ROSE: Thank you, Dr. Carey. Would you read the next question?

Q. This question is addressed to Dr. Rose. A patient had been taking thyroid pills, three grains a day for years. You expect from her description of her original symptoms that she did not have hypothyroidism at that time and should not have been started on thyroid. Are there any investigative procedures to test your contention after the patient's daily intake of thyroid is discontinued? How long will it take for her own thyroid hormone production to help turn to normal, and shall her intake of thyroid hormone be stopped at once or gradually?

DR. ROSE: This is a very common clinical problem. I should like to call your attention to a very interesting and useful article which appeared in the November 1951 issue of the *Annals of Internal Medicine*, by Johnson, Squires and Farquharson, of Toronto, dealing with the physiological effects of the administration of desiccated thyroid to persons with normal endogenous thyroid function. In reply to this specific question I would say that any attempt to evaluate the patient's own endogenous thyroid function while she was still taking three grains of desiccated thyroid daily, would be fruitless because of the distorting effect of such prolonged therapy upon the patient's own thyroid activity and because of the misleading changes in serum precipitable iodine and in metabolic rate and in the capacity of the patient's own thyroid to take up

traces of radioactive iodine. The only way to find out whether that woman really has hypothyroidism or not would be to withdraw the desiccated thyroid and when she has been without any of the drug at all for a period of two months then to study her thyroid function by the currently accepted methods. The time required for the patient's thyroid to regain its maximal pretreatment endogenous function varies considerably. According to some studies reported last year in the *New England Journal of Medicine*, by Greer, of Boston, based on recapture of normal ability to take up radioactive iodine, such normal ability may be regained in periods of time varying from two weeks of time up to eleven weeks after the cessation of thyroid medication. Of course it depends upon radioactive iodine uptake, as the major measure of thyroid self-function might not have been justifiable. It may require then as long as eleven weeks occasionally, even longer for a patient's own gland to bounce back, so to speak. The work reported by the Toronto group, however, suggests that even after years of thyroid feeding to a person not originally hypothyroid, that person's own thyroid gland can come back despite many years of suppressive effect exerted by thyroid therapy. So that to boil the thing down I'd say to study the patient's thyroid function while she is still taking thyroid would be useless. You should withdraw the thyroid and after a period of about two months then you can study the patient's thyroid function with some hope of learning the truth. The third part of the question, e.g., "should the thyroid be stopped abruptly or gradually." I think it is a pretty good general principle in endocrine therapy when you stop medication, (unless it must be stopped abruptly to avoid catastrophe), to do so gradually and you are less likely to precipitate an acute dislocation of endocrine interrelationships which may lead to very undesirable consequences. I'd suggest in this particular case cutting down gradually, putting the patient on two grains a day for a week and then one grain a day for a week and then a

grain every other day and tapering it off for three or four weeks. Wait two months and then study your patient's thyroid function.

Q. This question is addressed to Dr. Dixon. May the basal metabolic rate be elevated in anxiety states further complicating the differential diagnosis?

DR. DIXON: I mentioned that as a factor in anxiety neurosis the basal metabolic rate may be elevated. It usually isn't extremely elevated but it can be enough so as to make it a difficulty in establishing a definite diagnosis of thyroid disease. I had hoped for a chance to make a comment on the BMR from the point of view of the psychiatrist in practice. He sees many patients, who have been influenced by BMR findings. I feel that it certainly has been overemphasized and I am sure you will agree. It is only one diagnostic test and it certainly isn't foolproof; it can be influenced by so many factors. I would say the answer to the question is yes, and that in a psychoneurotic reaction with enough tension, and enough physiological upset due to anxiety, that there can be an elevation of BMR.

DR. ROSE: I might point out that two modifications of technique have been reported in the past few years which increase the value of the basal metabolism determination, or rather to put it the other way around, to eliminate some of the bugs from the method. The first of these was reported a couple of years ago by Dr. Bartels of The Lahey Clinic, which consists of the determination of the basal metabolic rate while the patient is under anesthesia induced by intravenous pentothal. By performing the test under these conditions artificial elevation of the basal metabolic rate produced by emotional tension or hyperventilation can be eliminated and you get a more nearly correct picture of the patient's true basal metabolic rate. The disadvantages of this method is that it requires a team, an experienced team, an anesthetist and a basal metabolism technician who have learned to work together. The patient has to be watched, of course, very closely and the jaw has to be held up so

that the mouthpiece will not leak. We have used it in a number of situations in the past couple of years since Bartels reported it, and we have found it occasionally very useful in attempting to decide whether a given patient was really ready for thyroidectomy or not. The second modification was just reported in the December issue of the *Journal of Clinical Endocrinology* by Dr. Rappaport and Dr. George Curtis, from Columbus, Ohio. It is what they call the determination of the somnolent metabolic rate, or the SMR instead of BMR. What they do is simply to put the patient to sleep with intravenous nembutal and they carry the procedure out as an office test. The patient comes in and they give him intravenous nembutal, after he has a couple of conventional BMR determinations and then they measure his metabolic rate while he is asleep. Both of these methods will probably prove to be useful in certain selected problems.

Q. Will some member of the panel say a word against x-ray treatment of thyroid disease? (laughter)

DR. ROSE: That sounds like it came from somebody who got burned somehow or other. Dr. Asper, would you care to take up the cudgel?

DR. ASPER: It is hard to say much against what is one of the very first treatments used for hyperthyroidism and was much in vogue between 1900 and 1925, and was still used as recently as 1930 and rather extensively. There are over ten thousand cases reported in the literature of x-radiation to the thyroid gland or the implantation of radon seeds into the thyroid. It is a treatment which has not been used so much of late since surgery has been so well developed, especially since patients were prepared with Lugol solution. However, there is no question but that in certain cases it works quite satisfactorily and we have used it in a patient within the past two years with very good results. It is said that external x-radiation to the thyroid gland is more effective in a patient who has not been previously treated with Lugol's solution, another reason supporting Dr. Rose in his state-

ment that before one uses Lugol's solution one must give consideration to its possible disadvantages.

DR. ROSE: Dr. Pancoast and Dr. Eugene Pendergrass and I had a fairly considerable experience with external irradiation of the thyroid over a period of twenty years or more during which we treated approximately eight hundred patients. We were able to get in selected cases—and the word “selected” should be emphasized—we were able to get about fifty-seven per cent of satisfactory results but it required usually several months before maximum response could be observed. There were occasional late undesirable side effects, burns, etc. The method has now been almost totally abandoned insofar as thyroid irradiation of the pituitary and sometimes of the orbits employed in the treatment of the hyperophthalmopathic type of Graves' disease is concerned.

Q. How does the protein bound iodine test compare with other tests of thyroid function?

DR. ROSE: I might presume to say a word or two in reply to that question. The measurement of the so-called serum protein bound iodine or serum precipitable iodine presumably measures that fraction of the total serum iodine which is bound to or incorporated within the thyroid hormone. Nobody is yet sure just what the thyroid hormone is, most people now believe it is probably thyroxin which is loosely bound to one of the fractions of serum albumin. The accurate performance of this test requires special skill and experience on the part of a technician. It is a complicated and laborious piece of laboratory work. Contamination from many sources must be rigidly excluded. Special apparatus is required and for this reason it has not yet become widely established as a routine hospital laboratory procedure. However, it is growing steadily in popularity and it is becoming more and more widely available as a diagnostic method. A normal concentration of serum bound iodine is extremely small, and this explains in part the difficulty of getting an accurate and reliable result. The nor-

mal range varies geographically to some extent from one part of the country to another. In this part of the country it is somewhere between four and eight gamma, that is thousandths of a milligram per one hundred cc's. There is some variation also in the normal range depending on the technique which is employed. There are several methods for its measurement. It should be remembered that the results can be affected by a number of factors, the administration of desiccated thyroid, the occurrence of disease in other organ systems, pregnancy, kidney disease, congestive heart failure, adrenal cortical insufficiency, all can affect the level of the serum precipitable iodine. If the patient has been taking iodine in any form even though that iodine has been inorganic, it is possible for the serum precipitable iodine to be artificially affected. The administration of antithyroid drugs such as thiouracil compounds can affect the level of the serum precipitable iodine and the administration of mercurial diuretics can cause artificial fluctuations. The consensus of opinion reported by those who have compared this method with the reliability of tracer studies, using radioactive iodine, inclines to the view that the tracer technique is more completely reliable than measurement of the serum precipitable iodine. I think it fair to say that when properly developed and controlled, it is a very useful addition to our diagnostic armamentarium and I believe it should properly be incorporated in the laboratory facilities of every first class hospital.

Q. What is the panel's opinion of the efficacy of propylthiouracil alone in the treatment of the average case of hyperthyroidism?

DR. ROSE: This is a very timely question and I'm going to pass it along to Dr. Asper.

DR. ASPER: Dr. Rose, one of the student nurses at our hospital recently calculated that it would be possible for a patient to take maintenance doses of propylthiouracil and come to the clinic at periodic intervals for twenty-two years for what it would cost a patient to have the thyroid gland removed. (laughter) In mak-

ing such a statement we do not advocate that the prolonged use of propylthiouracil is the treatment of choice but there is no doubt that patients who have moderate hyperthyroidism and a small diffuse goiter, especially if they are young women, will have a very satisfactory response to propylthiouracil when given over a prolonged period of time. In the patients that we have in our clinic, patients who are selected only in that they are willing to take the drug over a long period of time, we have had fifty per cent of them to have what appears to be a permanent remission of the disease. However, I think that this is open to considerable question because we know that even after surgery patients come back some five and ten years later with a recurrence of hyperthyroidism. One of our patients in whom we had thought the disease had been "cured" came back three years later with recurrence of the disease. It may be that propylthiouracil is only an agent which can be used to bring about an amelioration of the disease during its administration with perhaps all patients eventually having a relapse, but so far fifty per cent of our patients seem to do quite well after a prolonged period of administration. By prolonged periods it apparently *really* means a prolonged period because it is very clear that administration of propylthiouracil for a period of six months or less will result in a remission rate of almost ninety-five per cent of the patients, but when the drug is given for a year or longer, then the remission rate is about fifty per cent.

DR. ROSE: The use of these antithyroid compounds is of course of paramount importance to the general practitioner because it has placed in his hand a tool with which he can control thyrotoxicosis usually for as long as he chooses to keep the patient on it. I should like to emphasize however, that all of these antithyroid compounds are occasionally capable of producing undesirable or even quite dangerous sensitivity reactions. The propyl and methyl derivatives of thiouracil are very much less toxic than was thiouracil itself, but even these compounds must be regarded

as potentially toxic. The same thing is true of an antithyroid drug which we have found to be generally highly satisfactory and that is methylmercaptoimidazole as it is called, and it is marketed under the name of "tapazole." Even this compound will occasionally produce leukopenia. The manufacturers tell me they have received reports of an incidence of agranulopenia of serious degree in a little under 0.2 per cent in more than a thousand case reports which they have received. The response of patients to long continued therapy with these antithyroid drugs is of interest. We reviewed a group of forty-six patients all of whom had been on one form or another of these antithyroid drugs for a long period of time. They were selected cases in whom we started out deliberately with the hope of producing a permanent or sustained remission without any other therapy than antithyroid medication. Most of these forty-six patients had been followed for more than two years after the withdrawal of the medication and some of them had been followed for as long as seven years. We found somewhat to our surprise that of those forty-six, forty had remained in satisfactory remission and only six required some other form of treatment. A number of those forty, it is true had relapsed once or twice, sometimes three times but then eventually had gone into what we call a "permanent" or sustained remission.

Q. DR. FORT: A female patient of fifty years, with a large nodular goiter, who had received iodine for nine months, and whose basal metabolic rate is now plus eighty per cent, is to be prepared for operation with propylthiouracil. Should stable iodine be discontinued at this time?

DR. ROSE: Dr. Carey, would you care to answer that?

DR. CAREY: I would certainly continue the stable iodine because a sudden withdrawal carries with it a grave risk of precipitating a crisis. The antithyroid drugs are far too slow in their reaction to protect a patient throughout that period, so I believe that she should be started on the

antithyroid drugs, and that iodine should be continued up until the time of operation.

DR. ROSE: Dr. Rienhoff, would you agree to that or would you care to dissent?

DR. RIENHOFF: No, I think it should be continued. After all, I think all surgeons agree that if you do not continue iodine that you have a technical problem which is at least more difficult than if you have a sustained involution of the gland that you can only get with iodine. Otherwise you really have a vascular gland that persists in its hypertrophy and hyperplasia and vascularity which offers at least more difficult technicalities. There doesn't seem to be any harm in continuing the iodine along with the propylthiouracil.

Q. Dr. Asper, please discuss the use of radioactive iodine in metastatic carcinoma of the thyroid.

DR. ASPER: This also is in development. It appears that certain patients who have carcinoma of the thyroid are suitable candidates for intensive treatment with radioactive iodine. There are patients, however, in whom radioactive iodine may be used diagnostically in an attempt to determine whether or not metastases are due to thyroid cancer. However, in the presence of normal thyroid tissue in the neck, when a tracer dose of radioiodine is given, the iodine usually goes to the normal cells and is not accumulated by the carcinomatous cells. It therefore becomes necessary to remove all normal thyroid tissue from the neck before the metastases begin to develop any avidity for the iodine. As a diagnostic procedure for determining whether or not a metastasis is thyroid carcinoma, radioiodine has not been very successful except in a few cases.

When one uses radioiodine for thyroid cancer, large doses are required and usually it is necessary to attempt to induce the thyroid cancer to take up the radioiodine. The methods used to induce the tumor to take up radioiodine are administration of thyrotropic stimulating hormone (T.S.H.) thiouracil or propylthiouracil for

a period, then withdrawing it and administering radioiodine. The administration of antithyroid drug in a patient who has had the normal thyroid removed, will result in some stimulation of the metastatic tissue probably by the elaboration of TSH by the patient's pituitary gland. Then after withdrawing the antithyroid agent the tumor may take up significant quantities of radioiodine. There are patients reported in whom very satisfactory improvement has been obtained, however, I think radioiodine in the treatment of thyroid cancer has not lived up to the expectation that was held for it five or ten years ago.

Q. DR. FORT: If the antithyroid drugs block the iodination of the thyroid gland, how does the concurrent use of iodine and propylthiouracil prove beneficial?

DR. ROSE: Dr. Carey, would you undertake that?

DR. CAREY: Though the antithyroid drugs do prevent the thyroid from accepting large quantities of stable iodine, stable iodine does have the remarkable ability to prevent the hyperplasia that goes with the antithyroid drugs, and to lessen it once it has been established.

Q. DR. FORT: Dr. Dixon, please discuss your feelings as to the psychic phase in the etiology of Graves disease?

DR. DIXON: Well, that is of course a very controversial subject, very difficult to get convincing evidence, particularly to the practical minded surgeon, internist and others. Of the studies that have been done on many cases, there are three which I would refer to as good studies, two of them back in 1930's, both in New York, and more recent one at the thyroid clinic at Johns Hopkins Hospital, by Dr. Whitehorn and Dr. Lidtz. The ideas which have come out of these studies are in agreement as to the evidence found which is that emotional shocks or a strong emotional experience does have some relationship to the onset of the clinical thyroid disease. This of course is a question still open to debate. There are other more long range emotional problems in these patients' lives in the ones who

have been studied closely. There is evidence that thyrotoxicosis does relate to emotional conflict over the people close to them. One finds specific emotional problems simmering away for longer periods at the onset of clinical thyroid disease. These findings are based on careful examination of each patient and by noting their emotional response during the interview. In regard to talking about these problems, all I can say is that the investigators have gone into it carefully and come out with surprisingly similar ideas about the role of emotional problems both long range and acute emotional crises having some relationship to the onset and to the keeping alive of the disease.

Q. This is to Dr. Asper. If a hyperthyroid patient is being prepared for surgery on propylthiouracil and is sensitive to Lugol's solution, would you remove the propylthiouracil a few days before surgery?

DR. ASPER: No, sir, we have had such an experience and have kept the patient on propylthiouracil and had the gland removed without previous administration of Lugol's solution. Recently in a few patients in the clinic who have been receiving propylthiouracil for a prolonged period, two years or so, and have not had any reduction in the thyroid gland size, we have asked our surgeon confreres to remove the gland without previous administration of Lugol's solution. To our surprise these operations have gone extremely smooth. It is not felt, however, that such procedure should be advocated especially in patients who are treated only for a short period with propylthiouracil. One might add that when one uses propylthiouracil in preparation for surgery, that the drug should be given for a considerable period;—that is, at least three months—because it takes that long for the metabolism to be restored to normal. In such a patient who is sensitive to iodine, I think it might be safe to give the drug for a considerable period, a year or so, and then attempt to remove the gland without previous administration of iodine.

Q. DR. FORT: The final question will go to Dr. Rienhoff. Discuss indication for lymph node (block dissection of the neck) in malignancy of the thyroid.

DR. RIENHOFF: I think that was brought out very well by Dr. Berthrong. We divided our carcinomatous tumors into really three main groups, if you leave out the Hürthle cells. One of them is the intracystic papillary adenocarcinoma which undoubtedly goes by the lymph stream. It is probably the only instance in which you go into the neck to remove the lymph glands and then find it has thyroid tissue in it and you then do a hemilobectomy. I prefer a double partial lobectomy, but for this tumor you must do a dissection of the glands of the neck. I don't know exactly what some people mean now by a radical dissection. If you go by the radical dissection that we used to do in the days of Dr. Halsted and Dr. George Crile, I'd say no. We do take the lymph glands out from under the internal jugular, and the deep cervical glands on the side in which the lobe that we presume or assume does contain the tumor. On the other hand the so-called and the most paradoxical term I have ever heard, benign metastasizing adenoma. There isn't anything benign about metastasizing in my mind, but they do say that and they invade blood vessels. Dr. Berthrong pointed out, they do not metastasize through the lymphatics, they go through the blood stream. Now, those tumors can be removed and I don't think it is necessary to do a block dissection of the neck. Infiltrating carcinoma, is so rapidly growing, (the undifferentiated cell carcinoma) that I think they metastasize both by the blood stream and the lymphatics. Dr. Rose, may I make a remark about iodine and propylthiouracil? One of the things that has interested us for the last several years, has been the study of biopsies of the gland before, during and after propylthiouracil, in those who have been on the drug for two or three years. The thing that fascinates me about these drugs is not so much that I think we want to keep them all for sur-

gery, because I said in the beginning I'm completely convinced that medicinal therapy will finally answer the question. However, when thiouracil, which blocks the iodination of diiodotyrosine to thyroxin, is administered the gland undergoes hypertrophy and hyperplasia and then you give Lugol's solution and for some reason or other colloid is thrown down. In the days before the antithyroid drugs, we gave Lugol's solution and we had a colloid tamponade which cut down not only the lymph but the blood vascular circulation and the two processes seem to be entirely different; whether the iodine affects the epithelial cell we don't know, but it certainly will produce colloid. Where the colloid comes from we don't know but we do know that when blood thyroxin is down, and when blood iodine is down to normal you have a complete remission

from propylthiouracil. Even then, when you give Lugol's solution, you can precipitate colloid. I think the implementation of these drugs is fascinating and that they give us some tools to try to understand the mechanism of the thyroid gland. Evidently the two, iodine and propylthiouracil have two entirely different actions. It is fascinating to know why iodine can be precipitated in the absence of thyroxin production.

DR. McLANAHAN: I don't know how many sets of the Encyclopedia Britannica we have given away tonight, but we certainly have succeeded in escaping with a minimum number of contusions and lacerations among the members of the panel. I want to thank all of them for their splendid cooperation and say good night to all of them.

LINGUAL THYROID¹

ZACK J. WATERS, M.D., KENDRICK McCULLOUGH, M.D. AND
NATHANIEL R. THOMAS, M.D.

The first case report of lingual thyroid is credited by all writers to Hunt, who presented a case report in 1865.

Lingual thyroid or lingual goitre has been the subject of complete treatises, notably at the hands of continental writers. Dore, in 1922, reviewed the literature and presumably brought it to date with a total of 80 cases, his own making 81. It is possible, however, to identify between Hunt's report in 1865 and Dore's thesis in 1922, 91 additional cases, or a total of 172 cases. In 1922, two reports were published in addition to Dore's. Subsequent to Dore's publication, 72 cases have been reported. Recent writers have referred rather loosely to "about 130 cases reported in the literature," but the total is nearer 242.

¹ From the Departments of Otolaryngology and Pathology, Peninsula General Hospital, Salisbury, Maryland.

Eiselberg, as well as many other authors, give credit to Verneuil for first recording the presence and identification of thyroid gland tissue elsewhere in the neck than the main thyroid body. Verneuil himself, however (1853) gives prior credit to Cruveilhier (1852) for recognizing thyroid tissue elsewhere in the neck than the normal location and to Le Gendre (1852) for prior description of the pyramid, along which they found thyroid rests. Says Verneuil: "I have little to add to this description (Cruveilhier's). In later times, in dissecting the insertion of the muscles of the tongue to the hyoid bone, I have run across a small mass of tissue of glandular appearance, strongly adherent to the lower part of the superior border of that bone, between the geniohyoid and the genioglossus. This mass was red, soft, buried; of the volume of a large pea, with a smooth surface, of a homogeneous ap-

pearance; I have examined it microscopically and found thyroid gland tissue."

Lahey (1924) identifies aberrant thyroids according to location as follows: Those which remain at the foramen caecum are the true lingual goitres; those within the tongue, the intralingual goitres; those below the tongue, the sublingual goitres; those in front of the larynx, the pre-

Thyroid anomalies occurring in the tongue are of interest to the surgeon not only because of the practical problems involved in their surgical treatment but also because of their embryologic origin and the various parenchymatous changes to which they are subject. The favored site for the occurrence of thyroid tissue in the tongue is at its pharyngeal portion in the region of the



FIG. 1. Sketch of tumor mass, tongue drawn forward, showing contact with uvula and palate with ulceration

laryngeal goitres. Two other locations are within the superior mediastinum and those just outside the sternomastoid muscle in the posterior triangle of the neck. "Allied accessory thyroid" is an extruded adenoma still attached to the thyroid by fibrous band. "Pseudoaccessory thyroid" has an isthmus of true thyroid tissue, joining the mass to the thyroid. "True accessory thyroid" has no connection with the normal gland.

foramen caecum. Lingual goiter should be applied to hypertrophic thyroid tissue at the base of the tongue in those instances of nonmigration of the thyroid anlage from the region of the foramen caecum.

Lingual thyroid is essentially an embryological malformation, a vestigial rest appearing on the base of or within the tongue, or below it along the course of the thyroglossal duct of His. We can surmise no cause for this malformation.

It is found in women in seventy-four percent of the cases reported (78 in the female, 27 in the male, the sex not being indicated in 37 cases).

It is reported that in seventy percent of the cases the thyroid in the neck is absent, a fact,

on the base of the tongue. The referred diagnosis was "cyst of the tongue."

Family history: She has five brothers and three sisters, all living and well.

Past history: She had rickets in early childhood

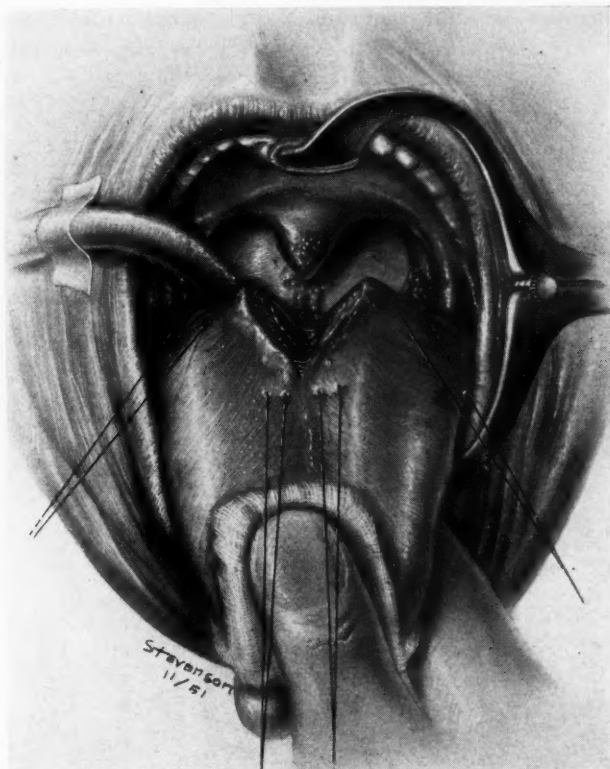


FIG. 2. Sketch of V shaped portion of tumor mass excised, traction sutures and emergency ligatures in place. (Note here ulceration of uvula, palate and posterior pharyngeal wall.)

which calls for consideration before surgical treatment is instituted.

REPORT OF A CASE

B. T. is a white female, aged 12, fairly well developed, moderately nervous, referred to me by one of us who had seen the patient on the previous day, February 22, 1951, complaining of a bloody discharge from the mouth of several days duration; also difficulty in swallowing, muffled speech, and a marked choking sensation. The referring physician noticed a large raw mass

and did not walk until the age of three. Usual childhood diseases. The history elicited from the family was that her nervousness dated back to December 1950, or three months previous. The mother had noticed for several weeks that there was a bloody mucous-like discharge on the pillows in the morning and occasionally the patient would spit up some blood-tinted mucous. Difficulty in swallowing had become rather pronounced, with some pain, and a definite so-called "thickening" or impairment in speech, also of several days duration.

Menstrual history: She began menstruation at the age of 11, regular, fair flow with little or no cramps.

Physical examination: The patient is an unusually cooperative, moderately nervous child, weighing 100 pounds, blood pressure 120/80, pulse 96, regular, no murmur. Physical examina-

tongue (See Figure 1). The throat was then sprayed with 2% pontocaine solution and an indirect laryngoscopy was performed. The mass was seen to occupy the most posterior aspect of the dorsum of the tongue and had no continuity with other structures of the pharynx or larynx. No other growths were noted. A direct laryn-

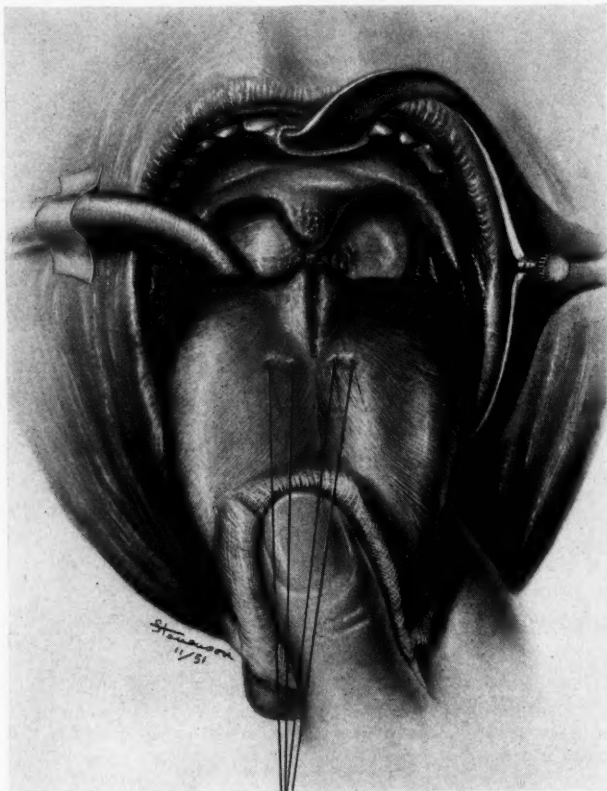


FIG. 3. Sketch showing approximation of remaining tumor mass with No. 0 braided silk sutures. (Note marked increase in pharyngeal space and airway.)

tion was essentially negative as far as the nose and throat was concerned except for hypertrophied and infected tonsils and a large, soft, hemispherical, elastic mass in the midline of the dorsum of the tongue, the mass measuring about 3 cm. in width, 4 cm. in length, and $1\frac{1}{2}$ cm. in height. The apex of this mass was ulcerated; the color was reddish. It was covered, except for the ulcerated area, by the mucous membrane of the

glossopharynx. Indirect laryngoscopy was done and the same findings were noted. It could be seen that the apex of this mass during the process of deglutition was making contact with the palate; hence, the explanation of the ulceration and difficulty in swallowing. An attempt was made to aspirate its contents, using a 20 gauge needle and 5 cc. syringe, but with no avail; the thought being a possibility of a cyst of the tongue.

The patient was admitted to the Peninsula General Hospital on February 23 and on February 24 a further attempt was made to establish a diagnosis and, under local anesthesia, consisting of 2% pontocaine spray, augmented by $1\frac{1}{2}$ grains of nembutal given $1\frac{1}{2}$ hours before examination and $\frac{1}{2}$ grain codeine given 45 minutes before time of operation, and this further augmented by local

showed Ectopic Thyroid Gland-Oral Cavity. The basal metabolism on this day, being done in the early morning previous to the above procedure, was found to be plus 15. On admission, February 23, the blood count showed a rather marked reduction in hemoglobin and a moderate drop in red blood cells. The urinalysis was normal on admission.

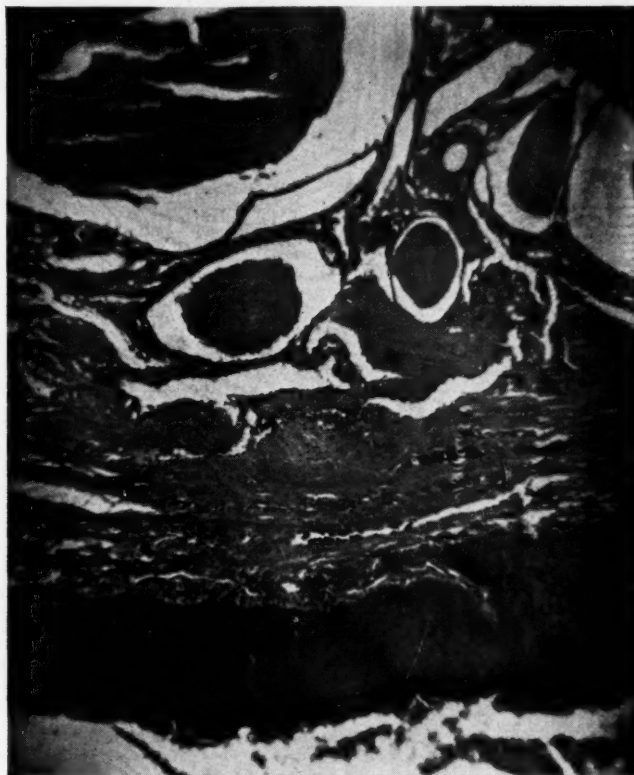


FIG. 4. Biopsy of Mass— $\times 1000$ Hematoxylin—eosin stain. 6 mm. thickness

infiltration around the circumference of the mass with novacaine 1% with adrenalin chloride; a small elliptical incision was made from the apex down through the entire substance of the mass; removing a small "watermelon-like" slice. Very little bleeding was encountered and two 4-0 silk sutures were used to approximate the edges. This specimen was sent to the laboratory and a frozen section requested. The frozen section

Report of First Biopsy

Specimen is a soft red fragment: 1 by 0.7 cm.

Frozen section shows a mucosal surface with stratified squamous epithelium. Attached to it is a glandular structure resembling thyroid.

The fragment on paraffin section, shows a covering of mucosa of the oral type. Beneath it is an area of thyroid tissue with large glandular acini filled with colloid. (See Figure 4).

On the morning of February 26, 1951, under general anesthesia, an endotracheal tube having been passed without any difficulty, the tongue being pulled well forward by two silk sutures placed on either side near its tip, and with suitable ligatures already in position to be tied lateral

the endotracheal tube and it was not found necessary to tie the sutures previously placed laterally on either side of the mass.

The patient was returned from the operating room in excellent condition and a transfusion already prepared was not found necessary. On

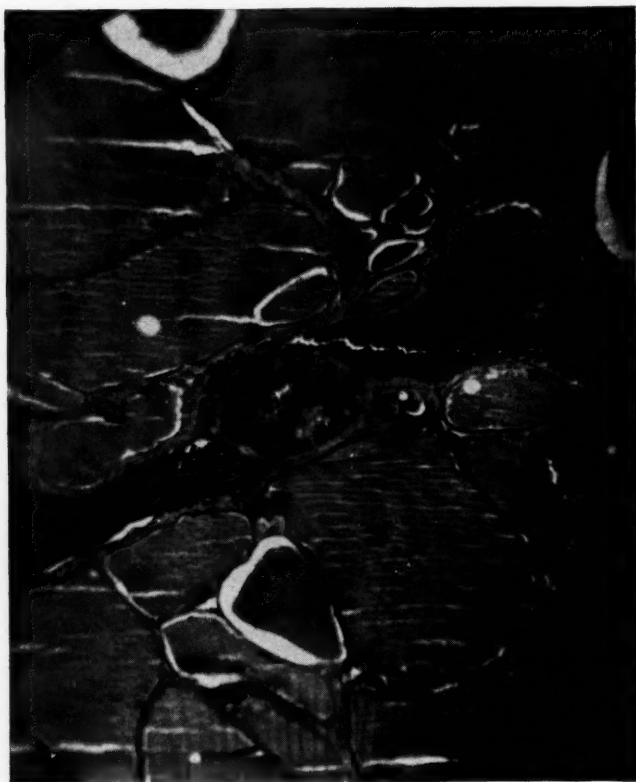


FIG. 5. Section of Interior of Mass— $\times 1000$ Hematoxylin-eosin stain. 6 mm. thickness

to the mass on the dorsum and posteriorly; a subtotal removal of this thyroid tissue was performed (See Figure 2). An elliptical incision was made and an equal portion taken on either side of the center through the entire thickness of the visible portion of the mass. Approximately one-half of the visible mass was removed in this manner. The edges were carefully approximated with No. 0 braided silk sutures (See Figure 3). Not too much bleeding was encountered although the pharynx had been carefully packed around

March 3, 1951 the basal metabolism rate was plus 5.

Report of Examination of Mass Removed at Operation

An irregular piece of firm, brown tissue is 2 by 1 cm. with mucosa on one side.

Histologic examination shows thyroid tissue with large acini filled with colloid. Over it is mucosa of the type found in the mouth. The site of the biopsy is marked by a hemorrhagic area

in the mucosa which includes suture material. (See Figure 5).

COMMENTS

The authors felt that the BMR plus 15 was represented by the mass on the base of the tongue and that extreme care must be taken in its removal lest we find our patient postoperative in a state of myxedema thus making it necessary that she take thyroid for the rest of her life. Furthermore, we were cognizant that this mass fluctuated in size and that the symptoms were enhanced by menstruation, and it was just following the menstrual period that the patient was seen. However, in view of the symptoms aforementioned and discomfort, plus the moderate and continuous loss of blood, a partial or subtotal removal of this mass was deemed necessary without further ado.

Since the surgery was to be performed by one of us, an otolaryngologist, the oral route was elected. We had no hesitancy in explaining to the family prior to the operation that this mass was thyroid tumor and that its removal might be attended by some gain in weight or necessitate the use of thyroid. Fortunately, a monthly check over a twelve-month period has failed to present any evidence of dysfunction, and we feel reasonably sure that enough time has elapsed that myxedema present itself. No such symptoms or signs are apparent.

In July 1951 a tonsillectomy and adenoidec-tomy was performed with an uneventful recovery. A BMR has been done each month since the date of operation and has ranged from a plus 5 to a minus 4.

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Symposium on The Doctor In Court will be continued in the June Journal.

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COURT RULES THAT KEY SECTIONS OF LOBBYING LAW ARE UNCONSTITUTIONAL

Capitol Clinic, A. M. A., Vol. 3, No. 12, March 25, 1952

A special three-judge U. S. District Court has ruled that the key provisions of the federal lobbying law are in violation of either the first amendment or the "due process" clause of the fifth amendment to the Constitution and are unconstitutional. The Justice Department may appeal directly to the Supreme Court, and there is a possibility that Congress will amend the law to conform to the lower court's decision. If the lower court is sustained, and if Congress fails to act, only one section of the law will remain, that requiring *individuals* who lobby for *pay or other considerations* to register with the Clerk of the House and with the Secretary of the Senate and to file certain quarterly reports. The court did not rule on this section. However, inasmuch as the penalty provisions were held unconstitutional, there would be a question as to the effectiveness even of this section. *Write to AMA's Washington Office if you want a copy of the court's decision.*

Component Medical Societies

ALLEGANY-GARRETT COUNTY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. John A. Dyer, formerly of 247 Virginia Avenue, Cumberland, has been promoted to the rank of captain of Malden Air Force Base, Missouri, where he is flight surgeon and head of the medical department.

Captain Dyer was stationed at Randolph Field, Texas, and Columbus, Mississippi, prior to being sent to Missouri. His wife and daughter, Carolyn, are with him. He is the son of Dr. and Mrs. Vernon L. Dyer, Petersburg, West Virginia.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.

Journal Representative

The basic plan for the new addition and improvements to the Anne Arundel General Hospital has been approved by the State Planning Commission. Construction is expected to begin about July 1, 1952. The new orthopedic rooms, including a waiting room and a supply room, have been completed and are now in use at the hospital.

Dr. Harold R. Bohlman lectured to the Maryland State Nurses Association, including nurses from Anne Arundel, Calvert and Prince George's Counties, on the subject of recent and present cases of orthopedics with x-ray discussions. There was a large attendance for this first lecture.

Dr. J. Howard Beard, of the County Health Department, spoke yesterday to the Anne Arundel County nurses on the formation of Civil Defense units. Approximately fifty nurses were present.

BALTIMORE COUNTY MEDICAL ASSOCIATION

DONALD L. SOMERVILLE, M.D.

Journal Representative

The Baltimore County Medical Association held its monthly meeting on February 20, 1952, at the

Mullineaux Restaurant in Catonsville. The guest speaker was Dr. Lawrence Schulman, of the Johns Hopkins School of Medicine. An excellent paper on the use of ACTH and Cortisone was presented.

After discussing various aspects of the use of these hormones, Dr. Schulman stressed the fact that proper laboratory workup and followup are of utmost importance. These drugs cause changes in many systems of the body, and it is essential to keep check on the changes. As the speaker stated, "These hormones are not a panacea, nor are they a poison. They must be used wisely and cautiously, if they are to be used at all." The presentation was accompanied by a film on ACTH. The film showed some of the dramatic results one may get at times with the use of these drugs.

In the business section of the meeting, the revised constitution and by-laws were accepted by the membership at large. The newly formed Public Relations Committee presented some of its plans for the coming year. Plans were formulated for the designing of an emblem or insignia. The idea of an art contest among county high schools for the designation of such an emblem was discussed. This plan is to be further investigated.

The Public Relations Committee also brought up the possibility of blood typing all county residents as part of the civil defense effort. This is to be discussed with the State Civil Defense Authorities.

The Baltimore County Medical Association held its monthly luncheon meeting at the Rosewood State Training School on March 19th. Through the courtesy of Dr. George Wadsworth, Rosewood Superintendent, a wonderful chicken dinner was served to the members.

A short business meeting followed the luncheon.

After many faithful and devoted years of service, Dr. Frank Glantz tendered his resignation as Historian. His position was immediately filled by Dr. George Medairy.

An Art Contest which was brought up by the Public Relations Committee at the February meeting, was again discussed. This contest is to be held among all students of the county high schools. The purpose of the contest is to obtain a design for an

emblem or insignia to be used by the Baltimore County Medical Association. The contest has been approved by the County Board of Education and will be more fully publicized in the very near future.

The scientific part of the meeting was extremely interesting. The program consisted of a symposium on "The Mongoloid Child." This subject was presented in various aspects by members of the Rosewood Staff under the leadership of Dr. George Smith, Consulting Neurosurgeon of the University of Maryland. He introduced the subject and gave a discussion on the neurology involved. The following men also spoke:

Dr. Harry Butler—Physical characteristics and presentation of typical mongoloid patients.

Dr. Charles Ward—Endocrine patterns and their relationship to treatment.

Dr. John Brackin—X-ray findings in mongoloids.

Dr. Samuel Scalia—Congenital abnormalities of the heart among mongoloids.

It was stressed that early diagnosis is very important, for these children require institutional care. Many of them can be given some form of training to better their status in life.

MONTGOMERY COUNTY MEDICAL SOCIETY

L. MARSHALL CUVILLIER, JR., M.D.

Journal Representative

The monthly meeting of the Society, March 18th, was highlighted by the presence of almost fifty physician's wives and one physician's husband. This was the annual joint meeting with the women's auxiliary and an active campaign for increased membership was launched by them.

An interesting scientific presentation was made by

Dr. Hugh Hussey of Georgetown University, giving views on latest diagnostic and treatment procedures for gastro-intestinal bleeding.

After this scientific lecture, the business meeting was conducted and elections of officers accomplished. The panel as elected for 1953, agreed totally with recommendations of the nominating committee. All officers were unanimously elected. Only one opposing nomination was made and he requested withdrawal of his name.

Officers for 1953 are: *President*, William S. Murphy, Rockville, Maryland; *Vice President*, Austin B. Rohrbaugh, Jr., Chevy Chase, Maryland; *Secretary*, L. Marshall Cuvillier, Jr., Silver Spring, Maryland; *Treasurer*, Henry P. Laughlin, Chevy Chase, Maryland.

Delegates: Claude W. Mitchell, Silver Spring, Maryland, and William W. Welsh, Rockville, Maryland.

Alternate Delegates: John G. Bail, Bethesda, Maryland, and W. McKendree Boyer, Damascus, Maryland.

New Member to Board of Censors: Wilfred W. Eastman, Silver Spring, Maryland.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

SAMUEL J. N. SUGAR, M.D.

Journal Representative

At the April meeting of the Prince George's County Medical Society, Dr. Marshall Sanford spoke on Treatment of Bleeding Esophageal Varices.

Plans for a Golf Tournament, to be held in June, have been completed by Dr. Musser. Dinner and Entertainment will follow the afternoon of Golf, at the Prince George's Golf and Country Club.

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Don't miss the Annual Convention, Woman's Auxiliary to the American Medical Association June 8-13, 1952, at The Conrad Hilton Hotel, Chicago, Illinois. Make reservations now! Notify Mrs. Charles H. Williams, President, 1632 Reisterstown Road, Pikesville, Maryland, as soon as you know that you are going. She may want you as a delegate!

Library

RECENT ADDITIONS IN THE LIBRARY

1. Altschul, Rudolf, Selected Studies on Arterio-Sclerosis.
2. Benedict, Edward B., Endoscopy.
3. Berman, Jacob K., Principles and Practice of Surgery.
4. Brain, W. Russell, Diseases of the Nervous System. 4th Ed. 1951.
5. Brown-McDowell's, Plastic Surgery of the Nose.
6. Cecil, The Specialties in General Practice (1951).
7. Crile, George, Practical Aspects of Thyroid Disease.
8. Cullen and Gross, Manual of Medical Emergencies.
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REED-KEOGH BILLS

Secretary's Letter, No. 212, March 21, 1952

Instead of urging inclusion of doctors under Social Security, the A. M. A. is joining hands with the American Bar Association, the American Dental Association, architects, engineers, accountants and other professional groups in support of the Reed-Keogh bills, which provide for exclusion of certain portions of earned income from federal income taxes if those amounts are used to buy a pension.

These bill have been approved in principle twice by the House of Delegates of the Medical and Chirurgical Faculty.

Health Departments

MARYLAND STATE DEPARTMENT OF HEALTH

Some Changes in Communicable Disease Reporting

By action of the State Board of Health, and in line with policies current in other States and in the U. S. Public Health Service, the list of communicable diseases which must be reported to county and city health officers in the State of Maryland, has been modified.

Added to the list are the following diseases: Hepatitis, infectious; Hepatitis, serum; Leptospirosis, including Weil's disease.

Dropped from the list were: Influenza, Pneumonia, Puerperal infections, Rheumatic fever.

This leaves the complete list of reportable diseases as follows:

Amebiasis	Non-paralytic
Anthrax	Unspecified
Botulism	Psittacosis
Brucellosis	Rabies in man
Chickenpox	Rabies in animals
Cholera	Rocky Mountain spotted fever
Dengue	Salmonellosis (Paratyphoid)
Diarrhea (newborn)	Shigellosis (Dysentery)
Diphtheria	Smallpox
German measles	Streptococcal sore throat in-
Glanders	cluding scarlet fever
Hepatitis, infectious, including	Tetanus
hepatitis, serum	Trachoma
Infectious encephalitis (by	Trichinosis
etiology if known)	Tuberculosis (all forms)
Leprosy	Tularemia
Leptospirosis, including Weil's	Typhoid fever
disease	Typhus fever, endemic
Malaria	Typhus fever, epidemic
Measles	Yellow fever
Meningococcal meningitis and	Venereal diseases
meningococcemia	Chancroid
Mumps	Gonorrhea
Ophthalmia neonatorum	Granuloma inguinale
Pertussis (whooping cough)	Lymphogranuloma vene-
Plague	reum
Poliomyelitis	Syphilis
Paralytic	Primary and secondary
	All other

In an effort to inform practitioners of the preva-

lence of reportable disease in the community, a monthly report of communicable diseases for the State of Maryland will be published in each issue of the Maryland State Medical Journal. (See page 255).

Before making the changes in the diseases to be reported, a review of the Morbidity Reporting was submitted to the board by Dr. James R. Strain, epidemiologist assigned by the U. S. Public Health Service to the Maryland Health Department. The purposes of morbidity reporting were described as follows:

1. To make it possible to begin control measures at the time of their greatest potential effectiveness.
2. To measure the effectiveness of existing programs of prevention and to make possible further improvement.
3. To collect and analyze the statistical data necessary for immediate and future guidance of administrative procedures.
4. To disseminate knowledge of the prevalence of reportable disease in the community and to secure the cooperation of the general public in its prevention.

"Since routing morbidity reporting requires the regular and effective cooperation of many individuals who receive no compensation for the service," the report points out, "it is evident that the list of diseases to be reported should be limited to those conditions whose reporting is clearly necessary for the fulfillment of the above purposes."

Commenting on the omission of influenza and pneumonia, the report indicates "All efforts at the prevention of acute respiratory diseases have up to this time been completely futile and their diagnosis is so uncertain that individual case reports are of no statistical value.

"It is, however, desirable that the unusual prevalence of respiratory diseases or the appearance of new types be reported. As these diseases seem to be gaining in relative importance, it is essential that effort be made to develop new methods for their diagnosis and control."

During the 48th annual conference of the State and Territorial Health Officers held October 19-22 of 1949, the Infectious Disease Committee made the

following recommendations on the subject: "The Public Health Service study and survey present reporting requirements and make recommendations concerning any changes which are deemed advisable." The Service later reported that "Influenza reports are notoriously inaccurate and more useful data regarding the occurrence of this disease will be obtained by a plan of reporting of epidemics." This was also the feeling concerning pneumonia. This committee went on to state—"... individual case reporting of influenza is grossly unsatisfactory because the disease cannot be diagnosed clinically and is indistinguishable from many other types of common endemic and epidemic manifestation covering wide expanses of territory almost simultaneously, and causing a degree of increased morbidity and absenteeism sufficient to become readily apparent to the general public. It is relatively easy for a health officer to secure a qualitative description of the occurrence and extent of an influenza epidemic in his jurisdiction by telephoning schools and a few major industries to determine roughly absenteeism for respiratory disease. If local health officers are instructed to report such events to the State Epidemiologist, he in turn could quickly secure a picture for the whole state more promptly and more accurately than he could by the more cumbersome impractical method of individual case reporting." They further recommended that some mechanism be devised for the recognition of any increase in the number of pneumonia deaths.

The consultants of the Communicable Disease Center of the Public Health Services on considering these proposals, expressed certain differences of opinion on the subject. At the conference of State Epidemiologists in Atlanta, Georgia in April 1951, however, these two groups of diseases were recommended to be dropped from routine reporting.

In association with the civil defense program, Dr. Allen W. Freeman wrote a memorandum to the county health officers on January 23, 1951 requesting a narrative report of any unusual prevalence of disease. The influenza information center of the World Health Organization has arranged with laboratories in each region of the United States to do diagnostic work with influenza. As soon as a positive test is made in any one of these laboratories, the result is made available to all public health personnel.

Rheumatic Fever:—It is recommended that Rheumatic fever be dropped from the list of reportable diseases since no immediate control measures are undertaken to prevent its spread. Dr. Edward Davens states also that the diagnosis of Rheumatic fever is, in many instances, extremely difficult and concludes from study of past reports of this disease, that they are grossly inaccurate and of no real value. His proposal has been discussed with Dr. J. Edmund Bradley, Chief of Pediatrics at the University of Maryland, Dr. Francis F. Schwentker of Johns Hopkins and Dr. E. Cowles Andrus of the Heart Association of Maryland. All agreed to the proposal for dropping this disease. They believe case-finding through special school and cardiac clinics to be a much more satisfactory approach.

Puerperal Infections:—Puerperal infections are now very rare. In fact we have had no cases reported in the past few years. This reduction in prevalence is thought to be due largely to the practice of aseptic technique and the prophylactic use of antibiotics.

Dr. John Whitridge, Consultant in Obstetrics for the Department, feels that due to the above facts and since all maternal deaths are thoroughly investigated by a medical committee, puerperal infections have virtually disappeared as a public health problem and the disease should be dropped from the list.

ADDITIONS TO THE LIST OF REPORTABLE DISEASES

It was recommended that certain diseases be added to the reportable list.

Infectious Hepatitis and Serum Hepatitis:—Diseases of this group are recommended to be routinely reported. There has been during and since the war years, an apparent increase in the number of such cases. Gamma Globulin has proven beneficial as an immediate preventive measure tending to prevent the spread of infectious hepatitis if given early to the contacts.

There have been several serious epidemics in our State during the past year and considerable amount of research is noted in progress on the subject. Much more needs to be done. With the increased use of human blood and blood products it is quite obvious that cases of serum hepatitis should be reported and the sources of infection discovered at the earliest possible moment. Reporting will also be of value in research.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, March 21-April 17, 1952

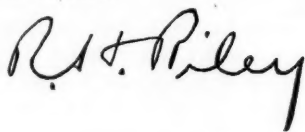
	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	STREP. SORE THROAT, INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																	
Local areas																	
Baltimore County...	47	—	9	3	252	2	4	—	25	—	—	1	29	1	12	—	10
Anne Arundel.....	10	—	4	—	42	3	13	—	6	—	—	4	5	—	5	—	3
Howard.....	—	—	—	—	2	—	—	—	1	—	—	—	2	—	—	—	—
Harford.....	36	—	107	—	59	2	19	—	—	—	1	—	1	—	1	m-2	2
Carroll.....	7	—	—	—	21	—	6	—	3	—	—	—	3	—	2	—	4
Frederick.....	3	—	2	1	60	—	8	—	4	—	—	—	—	—	—	—	4
Washington.....	1	—	9	—	39	1	—	—	2	—	—	—	4	—	1	—	1
Allegany.....	4	—	3	—	2	1	5	—	3	1	—	—	8	—	1	—	3
Garrett.....	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	4
Montgomery.....	32	—	16	—	158	—	21	—	19	—	—	—	27	3	—	—	4
Pr. George's.....	9	—	26	—	48	—	8	—	3	—	—	—	—	—	—	—	4
Calvert.....	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	1
Charles.....	1	—	—	—	4	1	—	—	1	—	—	—	—	—	—	—	1
Saint Mary's.....	—	—	—	—	7	—	—	—	—	—	—	—	—	3	1	—	2
Cecil.....	—	—	1	—	2	—	3	—	—	—	—	—	3	—	1	—	1
Kent.....	—	—	—	—	26	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	—	—	2	—	—	—	3	—	—	—	—	—	2	—	1
Caroline.....	1	—	—	—	4	—	—	—	—	—	—	—	2	—	—	t-2	—
Talbot.....	—	—	—	—	2	—	—	—	—	—	—	—	—	—	1	—	—
Dorchester.....	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—
Wicomico.....	6	—	—	1	26	—	1	—	3	—	—	—	5	—	8	—	2
Worcester.....	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—	—
Somerset.....	—	—	—	—	1	—	—	—	—	—	—	—	—	—	3	—	—
Total, counties...	157	0	177	5	760	11	88	0	73	1	1	5	92	7	39	—	47
Baltimore City.....	279	0	47	10	785	8	37	0	48	0	0	11	118	8	410	e-1	25
State																	
Mar 21-Apr 17, 1952	436	0	224	15	1545	19	125	0	121	1	1	16	210	15	449	—	72
Same period 1951...	494	11	176	47	597	6	726	0	117	3	2	35	194	25	409	—	70
5-year median.....	565	14	88	—	653	16	171	0	154	2	5	68	239	125	487	—	74
Cumulative totals																	
State																	
Year 1952 to date...	1707	4	501	98	7348	48	504	6	554	7	9	63	869	55	1919	—	316
Same period 1951...	1676	25	309	89	1228	29	2156	10	460	5	9	218	780	101	1987	—	241
5-year median.....	1990	101	205	—	1397	58	583	2	604	6	17	418	845	481	2062	—	325

e = infectious encephalitis.

m = malaria contracted outside the U. S. A.

t = tularemia, belated 1951 reports.

Weil's Disease or Leptospirosis:—Weil's disease, though not a problem in Maryland, is recommended to be reported. The disease is of national importance and over-all figures on prevalence should be available. With recent improvements in laboratory diagnosis it is likely that an increasing number of cases will be discovered. The disease is known to be widespread in the rat populations and reporting is necessary to further effective research into the many still obscure features of this disease.



Director

BALTIMORE CITY HEALTH DEPARTMENT

Fluoridation Approved for City Water Supply

On the basis of the best available scientific support, offered by the Medical and Chirurgical Faculty of Maryland, the Baltimore City Medical Society, the Baltimore City Dental Society, the Maryland State Department of Health and the National Institute of Dental Research of the U. S. Public Health Service, the City Council of Baltimore voted 17 to 4 in favor of the fluoridation of the city water supply on March 24, 1952. Others who encouraged this action included Dr. A. McGehee Harvey and Dr. Abel Wolman.

In the *Journal of the City Council of Baltimore* for March 18, 1952, pages 1238-1244, there appear the following Communications that were laid before the Council by its President, Mr. Arthur B. Price:

COMMUNICATION FROM BALTIMORE CITY DENTAL SOCIETY

Baltimore City Dental Society Resolution

Whereas, The Baltimore City Dental Society includes in its membership a great majority of the dentists of Baltimore; and

Whereas, The dentists of Baltimore are traditionally and by profession concerned with the dental health of the people of Baltimore; and

Whereas, Decay of the teeth poses a major health

problem affecting more than ninety per cent of the people of Baltimore; and

Whereas, People who live the first eight years of their lives where water supplies contain one part of fluorine in a million parts of water have less than one half as many teeth attacked by decay as do Baltimorean; and

Whereas, People who live their entire lives where water supplies contain one part of fluorine in a million parts of water do not have mottled teeth, brittle bones, poorly developed skeletons, nor increased susceptibility to rheumatism, arthritis, cancer, heart disease, hardening of the arteries, kidney disorder or premature death; and

Whereas, The safety of the presence of one part fluorine in a million parts of drinking water is substantiated in numerous epidemiological, clinical, laboratory and animal studies; be it therefore

Resolved, That the Baltimore City Dental Society reiterate its endorsement of the projected fluoridation of the public water supply of Baltimore given in 1950, and urge anew that the Mayor and City Council of Baltimore proceed to the end that the amount of fluorine present in the water supply be increased and maintained at the one part per million level as an economical, safe and effective means of reducing tooth decay and loss of teeth in coming generations of the people of this city.

Adopted, By the Executive Council of the Baltimore City Dental Society, Monday, March 10, 1952.

PAUL A. DEEMS, D.D.S.,
President.

COMMUNICATION FROM BALTIMORE CITY HEALTH DEPARTMENT

Baltimore City Health Department

Baltimore, March 13, 1952.

Dear Mr. Price,

Because of the communications published on pages 1148 and 1149 of the *Journal of the City Council of Baltimore* on March 3, 1952 in regard to the fluoridation of the Baltimore City water supply, I wish to send you the enclosed statement on this important public health matter that I presented, at the request of the Committee on Health for the City Council, at its hearing on March 3, 1952, and trust that the brief statement and this letter may be published in the *Journal of the City Council*.

You will see that all of the medical profession of the State of Maryland and the City of Baltimore, and the dental profession, and the Maryland State Board of Health favor the fluoridation of the Baltimore City water supply at this time.

May I add that the impression given on page 1149 of the Journal of the City Council under the heading "Doctor Raps Fluorine Use" is an entirely false one for these reasons:

Alfred Taylor of the University of Texas is a doctor of philosophy and not a physician. He is a biochemist research man. In my opinion, the results of his studies, after investigation by the U. S. Public Health Service, are worse than useless, because it is obvious he did not know what he was doing. In trying to study the effect of one part per million of fluorine in water, he experimented on 67 mice and, during the experiment, he fed them a dog chow food for their exclusive diet which, when analyzed, proved to contain 42 parts per million fluorine. Obviously, with this ignorance on his part, his experiments can mean nothing.

Sincerely yours,
HUNTINGTON WILLIAMS, M.D.
Commissioner of Health

STATEMENT OF DR. HUNTINGTON WILLIAMS ON
FLUORIDATION OF THE BALTIMORE CITY
WATER SUPPLY MARCH 3, 1952

In connection with Resolution No. 506 now before the Committee on Health of the Baltimore City Council asking for information on the fluoridation of the Baltimore City Water Supply.

The Commissioner of Health of Baltimore City believes thoroughly in

1. The fact that there is no substantial disagreement among competent scientists that the proposed fluoridation of Baltimore's water supply will have any effect at all of a deleterious nature on aging people, or on people of any age group.

In the Report on Fluoridation of Water Supplies of the National Research Council, published November 29, 1951, it is stated: "*In the accumulated experience there is no evidence that the prolonged ingestion of drinking water with a mean concentration of fluorides below the level causing mottled enamel would have adverse physiological effects.*"

The Chairman of the National Research Council Committee on this matter had as its Chairman, Dr. Kenneth F. Maxcy, Professor of Epidemiology, Dr. A. McGehee Harvey, Professor of Medicine and Dr. Abel Wolman, Professor of Sanitary Engineering; all three at the Johns Hopkins University, as three of the nine members of the Committee. Among the other members were representatives of the U. S. Public Health Service, the University of Cincinnati College of Medicine and the University of Minnesota School of Public Health.

This Report was printed in the January 1952 issue of *Baltimore Health News*.

2. The fact that any claims made that fluoride in the minute amounts to be added to the City Water Supply, one part per million, is harmful to persons suffering from rheumatism and arthritis, are not correct and cannot be scientifically confirmed.

In a leaflet published by the Baltimore City Health Department entitled "*Fluoridation—Questions and Answers*", Question No. 19 and its answer are as follows:

19. *Is it possible that fluoridation may cause defects in the body?*

Answer: No body defects attributable to water-borne fluorine below the 8 part per million level have ever been reported. Careful physical and x-ray examination of Newburgh children exposed to fluoridated water for six years disclosed no ill effects in the eyes, ears, bones, teeth or vital organs.

3. That the Baltimore City Health Department has been studying the matter of fluoridation of the City Water Supply since its first request to do so was received from Mayor Thomas D'Alesandro during the month of August, 1950.

That in November, 1950 the Baltimore City Dental Society approved the fluoridation of the Baltimore City Water Supply.

That in November, 1950 the Medical and Chirurgical Faculty of Maryland, the State Medical Society, placed itself on record as approving the fluoridation of the Baltimore City Water Supply.

That during 1951 the Maryland State Board of Health, after due consideration, approved the addition of fluoride to the city water supply of Hagerstown; and on December 20, 1951, approved the same procedure for Baltimore City.

4. That Dr. Maurice C. Pincoffs, Professor of Medicine at the University of Maryland, who serves with the Commissioner of Health of Baltimore City as a member of the Maryland State Board of Health, personally approves the fluoridation of the Baltimore City Water Supply as a safe and important procedure for the partial prevention of dental decay in children.

5. The fact that well water consumed by the citizens of Crisfield, Maryland, has been shown to contain three parts per million of fluoride in Somerset County and that they have been drinking this water for years and years without apparently any bad effects.

That in other Maryland communities there is naturally more than one part per million fluoride in the normal drinking water as follows:

Charles County:

Potomac Heights—3.00 parts per million
Indian Head— 2.5 parts per million
La Plata— 3.0 parts per million

Caroline County:

Denton— 1.30 parts per million

Dorchester County:

Cambridge— 1.10 parts per million

Talbot County:

Oxford— 1.80 parts per million

All of these are reports from the Maryland State Department of Health for Maryland areas, and there is no evidence that there has been any harmful effect from long continued drinking of these natural waters.

6. The fact that before chlorine was first used to prevent typhoid fever in public water supplies there was a feeling of uncertainty and possible danger to health which was clarified on a national basis in 1908.

The magnificent results as shown in the City Health Department Chart on the Typhoid Fever Death Rate from 1900 to 1950 from the adding of chlorine to the City Water Supply is now well accepted by the public and not to have chlorine

in the City Water Supply would be considered by nearly everyone as a public disgrace.

That the purpose of adding fluoride to the City Water Supply is identically the same, namely for the prevention of needless tooth decay and suffering for thousands of Baltimore children in the future, and for better adult health as the years go by.

7. That there is always some disagreement among scientists, and that this is perhaps the finest thing about science.

If it were not for some doubts and disagreement in science, there would be no true science.

From the best available evidence it would appear to the Commissioner of Health of Baltimore that well over 95% of the soundest scientific thought in the United States is in favor of the view that there is no danger to adjusting a city water supply to one part per million of fluoride and further that if this procedure is adopted that roughly two-thirds of all the dental decay in children, as the years go by, will be eliminated.

Because of the above the Commissioner of Health of Baltimore welcomes this opportunity to bring this available information to the members of the City Council as requested.

Huntington Williams, M.D.

Commissioner of Health

MEDICAL EDUCATION EXPANSION PROGRAM SURVEY

Secretary's Letter, No. 211, March 10, 1952

A survey conducted by the New York Times a few days ago showed the greatest expansion program in the history of medical education, to cost \$250,000,000, is now under way in this country.

The Times surveyed 80 medical colleges and 48 state commissioners of education through questionnaires.

According to the survey, medical colleges will spend, within the next few years, \$50,000,000 for laboratories, \$30,000,000 for classrooms and \$20,000,000 for dormitories. Another \$100,000,000 is earmarked for research and special projects. In addition, the immediate cost for establishing new medical institutions will run above \$50,000,000, making an overall expansion program of a quarter of a billion dollars.

"To meet the increasing demands for more physicians and medically-trained men," the Times said, "at least 10 states have taken steps to build new medical schools or expand their two-year basic science schools into four-year institutions.

"In the current academic year—1951-52—the medical colleges admitted the largest freshman classes in recent history, a total of 7,381. . . . Despite the expansions now taking place, large numbers of qualified applicants are unable to gain admittance to any medical college in this country. Many of them seek places in foreign institutions. The records indicate that 20,000 individuals applied for admission to American medical schools for the current college year. As many of them applied to more than one institution, the total number of applications was more than 70,000, or an average of 3.5 a student."

Insurance

BLUE CROSS

Since it was started in 1937, Blue Cross has progressed both in its size and in its administrative set-up. Growing pains and changes have come about as a result of experience and also from the increasing desire of the general public for assurance of hospital care.

The whole field of a pre-payment plan for hospitalization was instigated and developed by Blue Cross. As the idea and the Plan spread it became necessary for adjustments to be made. Blue Cross was making the people hospitalization conscious and as result changed its policy to enable larger groups to join.

Ever since its origin Blue Cross has been local in character. Each Plan has been set up to answer the needs of its own community. Each one reflects the economic realities of its own neighborhood. The differences in what the people in each section feel they want as basic coverage, are reflected by the different Plans in the programs they offer and their cost.

Because of this arrangement individual Blue Cross Plans have been able to include the major part of each community as members. As the membership has grown, so has the interest of the industries in the various communities. Almost every industry makes the prepayment hospitalization Plan available to its employees.

In many instances it is one of the "fringe benefits" in the Labor-Management contracts. The manage-

ment agrees to pay the employee's subscription to Blue Cross. If this type of contract does not exist then Management usually agrees to deduct the employee's Blue Cross subscription from his salary and pay it directly. While these systems have proved very successful at times a stumbling block has been encountered. Often an employer will have men working outside the area of one particular Blue Cross Plan.

In answer to this problem Blue Cross has established three different solutions.

A.) *The Inter-Plan Service Benefit Bank* is a reciprocal program for providing service benefits to subscribers of one participating Plan when hospitalized in a Member Hospital located in the area served by another participating Plan.

B.) *The Inter Plan Transfer Agreement* is a reciprocal program under which subscribers moving to the area of another participating Plan may transfer their membership.

C.) *Health Service, Inc.* is the national enrollment agency for Blue Cross Plans. It is empowered to contract with national firms for the provision of Blue Cross benefits. Such contracts provide uniform rates, benefits and enrollment and bill procedures on any given national account.

The latter, although not yet country-wide, is designed specifically for national accounts, while the first two are more for those who either are traveling or have moved.

Woman's Auxiliary to the Medical and Chirurgical Faculty

THE AUXILIARY AND NURSE RECRUITMENT

MRS. HARRY M. ROBINSON, JR.*

The Woman's Auxiliary to the Medical and Chirurgical Faculty has made a real beginning on its Nurse Recruitment Program. For instance, The Auxiliary to the Baltimore County Medical Association has not only established one student nurse in training, but is now starting a second. The Prince George's County Auxiliary has also successfully raised funds to educate a nurse. Auxiliaries to the Montgomery and Washington County Medical Societies are at the moment in the process of establishing scholarship funds.

On the state level, the Nursing Committee of The Woman's Auxiliary to the Medical and Chirurgical Faculty has been at work. A "Nurses Day" Tea was given by the Nursing Committee on Florence Nightingale's Birthday, May 12th, at The Medical and Chirurgical Faculty Building, in Baltimore, in honor of the nursing profession. The presidents of the four Auxiliaries which already have, or are establishing, nursing scholarships, Baltimore County, Prince George's, Montgomery, and Washington, acted as hostesses. Our honored guests were the President of the Maryland State Nurse's Association, the Presidents of the Nursing Alumnae Associations and the Deans and Directors of the Nursing Schools. Student government Presidents from the Nursing Schools were asked to pour. The movie, "Girls in White" was shown as a Nurse Recruitment aid.

In initiating a Nurse Recruitment Program it is important for your Auxiliary to first obtain the support of your Medical Society and to check with them on nursing needs. They will welcome any help, however small, in meeting the nationwide shortage of nurses.

Auxiliary members who are active in this endeavor should become familiar with the various schools of

nursing in the state. The directors of these schools should be interviewed and their cooperation sought. Auxiliary Nursing Committees should be familiar with the courses of training offered by the various schools in their locality and the number of students that can be accommodated in each of them. Some of the schools in this state have an educational program whereby a nurse can obtain a diploma after three years of training, whereas other schools offer a Bachelor of Science in Nursing after a four or five year course.

The best time to create interest in nursing is during a student's first and second year in high school before her final curriculum is chosen and while an opportunity exists to elect the necessary pre-nursing courses. The career of nursing should be presented as an attractive one and the desire to serve one's fellow man stimulated. We suggest that the principal of your high school be interested in this program and that he give your Auxiliary permission to have suitable speakers address the student body on nursing as a career. The speakers whom we select should be of high standing in the community, capable of presenting the subject in an interesting manner, and dedicated to the ideal of service to humanity. Outstanding physicians and older graduate nurses serve well in this capacity. They should be thoroughly briefed on our Auxiliary program before addressing the student however.

The excellent moving picture "Girls in White" is available from the American Hospital Association, 18 East Division St., Chicago 10, Ill. It is available in the 16 mm version (black and white sound, R. K. O. Pathe) for the average school showing or in 35 mm version for theatre showing. The cost for this film is \$4.00 for the first 3 days plus return postage. This film has been reviewed by our Auxiliary Nursing Committee and is highly recommended by them.

Good newspaper publicity will help your nurse recruitment efforts. The editor of your paper can best cooperate by writing up your scholarship and

* Chairman, Nurse Recruitment.

program events, and by running a series of articles on nursing as a career. He could print stories of famous women who have contributed so much to humanity by adopting this branch of medical science as a profession on Florence Nightingale's birthday.

If it is not possible for your Auxiliary to establish a scholarship fund perhaps you might consider a long term loan to be repaid without interest after graduation. These are matters which must be handled by the component Auxiliaries, as their finances dictate.

There is an effective radio program on nursing as a career in operation at the present time and students in your high school should be encouraged to listen to it. Again, the editor of your local newspaper can help by publishing the name of the station and the time when these programs can be heard. This should be done in a separate place in the paper where it will attract attention.

On or about May 12, which is Florence Nightingale's birthday, your local society could give a tea and invite all of the nurses in your locality to attend in uniform. Also invite the girls in the senior high school to attend this function. Some simple program should be arranged featuring the highlights of Miss Nightingale's life.

Encourage the formation of Future Nurse's Clubs in the senior high schools of your community. The club could meet twice each month during the school year and offer a program calculated to arouse interest in nursing as a profession. Local physicians, nurses, public health officers, and teachers from some of the training schools may serve as speakers. The girls, aided by a graduate nurse, may act out skits on some of the phases of nursing life. This would also be an excellent chance for the girls to learn personal hygiene and some of the simple rules basic to good health.

An essay contest on "Why I Want to be a Nurse" with a prize of some small amount of money would be an excellent way to stimulate interest among the girls in the senior high school class. This could be done with the cooperation of the principal, having as judges one of the local physicians and a nurse. Ask the editor of your local paper to publish the best one in a prominent place in his paper.

The State Auxiliary believes that the local Auxiliaries should initiate their own programs and consult the State Nurses Association only in an advisory capacity.

Our National Auxiliary, The Woman's Auxiliary to the A.M.A., is a member of the Committee on Careers in Nursing sponsored by the American Nurses Association. This organization has published a series of pamphlets which should be placed in physicians offices, schools, public libraries, and churches.

This is an Auxiliary responsibility, and the success or failure of the program depends on the effort we apply to it. The attempt to undermine our entire structure of free enterprise by the forces which advocate socialized medicine is constant. We do not want government subsidy, but must stand on our own feet. Let us endeavor to make a success of this task, and thereby improve the health of the community at large. It can be done!

"TODAY'S HEALTH"*

MRS. ELDRIDGE H. WOLFF, *Chairman*

"Today's Health," formerly called "Hygeia," is a twenty-eight year old magazine published by the American Medical Association in the interest of better health. Because so many "health" articles by self-styled, "experts" appear in current publications, it is most important that the lay public read this scientifically accurate health magazine.

Since there are two million persons *monthly* in doctor's offices, the American Medical Association stresses the great value of having copies of "Today's Health" in the office of every doctor. That is why "Today's Health" is sold to doctors and to the Woman's Auxiliary at half price. Does your husband subscribe?

This attractive magazine deals with the simple but fundamental health principles which affect our daily lives. It prints only carefully authenticated information about health and gives reliable information on quacks, faddists and cultists.

Cooperation with the medical profession is encouraged and each article emphasizes our Dependence upon *The Family Physician*.

"DOCTOR'S DAY" PROCLAIMED

Due to the efforts of Mrs. E. Paul Knotts, our "Doctor's Day" Chairman, Governor Theodore R.

* The A.M.A. Health Magazine.

McKeldin, this year proclaimed March 30th, to be "Doctor's Day" in Maryland. He presented his proclamation to Dr. J. Albert Chatard, who represented the Medical and Chirurgical Faculty. Television and still pictures of the Governor and Dr. Chatard were taken against a background of Auxiliary members. Dr. Chatard is the ideal representative of the Faculty which he has served so long and so well, and the Auxiliary was very proud to have him as "The Doctor" on "Doctor's Day." Newspaper publicity stressed the public health protection offered by the various Committees of the Medical and Chirurgical Faculty and the failure of the public to avail itself of the authentic information offered. Doctor E. Paul Knotts, as "Family Doctor of the Year," was written up on "Doctor's Day" in the "Sun" newspaper.

The "Doctor's Day" Proclamation reads, "whereas, our State and Nation owes a great debt to those unselfish physicians who labor long hours to care for our sick and who are constantly engaged in research to prevent human misery and suffering and

"Whereas, it is fit that we should from time to time pay tribute to those unselfish individuals who guard the health of our Nation,

"Now, therefore, I, Theodore R. McKeldin, Governor of the State of Maryland, do hereby proclaim Sunday March 30th, 1952, as "Doctor's Day" and do call upon all citizens of this State to remember their Physicians on that day and in some way express their appreciation to these guardians of the Nations health."

* * * * *

REGISTER AND VOTE

in the coming Presidential Election

HELP TO GET OUT THE VOTE

Baby-sit for voting mothers, drive people to the polls. This is the least the Auxiliary can do.

* * * * *

A HELP TO YOUR HUSBAND

One of our members, after consulting her husband, sent for the A.M.A. plaque for doctors offices, which

is a Public Relations Aid. Although neither she nor her husband felt that such a sign was "necessary" they are happily surprised at the favorable comment of patients ever since it has been posted in his office! It says "To All My Patients—I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly mutual understanding between doctor and patient." These plaques are one dollar (\$1.00) from the A.M.A., 535 North Dearborn Street, Chicago 10, Illinois.

QUOTABLE QUOTES

In America—"our progress came from an economic system—that grew out of a political philosophy—which came from a religious faith which put first the dignity and worth of individual man as a spiritual being, because he is a son of God.

"Most of us in American seem preoccupied with trying to preserve the material results which came from the Judeo Christian Concept of the nature of man. A more fundamental thing is to pay attention to the spiritual causes.

"You say "What can I do?" "Why isn't it" "the thing" for good people to work in politics? More of you have to be willing to be candidates yourselves and to let your husbands be candidates for public office."

The Honorable Walter H. Judd, M.D., Representative for Minnesota—in speech to National Auxiliary.

AUXILIARY NEWS

The Woman's Auxiliary to the Baltimore City Medical Society has elected new officers, they are, *President*, Mrs. Albert E. Goldstein; *President-Elect*, Mrs. Thomas Webster; *First Vice-President*, Mrs. E. Roderick Shipley; *Second Vice-President*, Mrs. J. Arthur York; *Recording Secretary*, Mrs. Homer Todd; *Corresponding Secretary*, Mrs. Ellsworth Cook; *Treasurer*, Mrs. Harry C. Bowie; *Parliamentarian*, Mrs. Howard M. Kern; *Assistant Parliamentarian*, Mrs. J. Frank Hewitt.

THE BALTIMORE COUNTY AUXILIARYS'

"Doctor's Day" Dance, which raised funds for a second Nursing Scholarship was such a social success that some of the doctors have suggested holding another in the Fall. Congratulations!

The newly elected officers of the Woman's Auxiliary to the WASHINGTON COUNTY MEDICAL SOCIETY, are: *President*, Mrs. S. R. Wells; *Presi-*

dent-Elect and First Vice-President, Mrs. Gerald W. LeVan; *Second Vice-President*, Mrs. John H. Hornbaker; *Recording Secretary*, Mrs. J. G. Warden; *Corresponding Secretary*, Mrs. O. D. Sprecher; *Treasurer*, Mrs. John A. Moran; *Parliamentarian*, Mrs. Sidney Novenstein. Washington County held a very fine program on Civil Defense on April 22nd.

FEDERAL, STATE MEDICAL STOCKPILES MAY EXCEED \$80 MILLION BY MID-YEAR

Capitol Clinic, A. M. A., Vol. 3, No. 13, April 1, 1952

Latest Civil Defense Administration figures indicate total federal and state stockpiles of medical supplies on hand or on order by July 1 may amount to \$80.5 million. Of this, CDA has committed nearly all of the \$50 million voted by Congress for exclusively *federal regional stockpiles*. In addition, CDA already has given states \$10.5 million which they in turn have matched on a 50-50 basis for *local supplies*. CDA has on hand about \$9.5 million from the original matching fund appropriation which Congress has said may be used for the *Federal* stockpile, provided it's committed by June 30.

CDA explains it has the \$9.5 million left over because (a) five states containing critical target areas are not yet participating in the federal-state program, (b) market prices of some supplies have dropped, effecting savings, and (c) additional savings were achieved through simplification of specifications of some items. The states that did not join in the program by the March 15 deadline are Alabama, Georgia, Texas, Louisiana and Illinois.

Civil Defense Administrator Millard Caldwell, meanwhile, had informed Chairman Brien McMahon of Joint Committee on Atomic Energy that medical stockpiling is "unsatisfactory both in volume and quantities of supplies available." Caldwell estimates funds voted by Congress so far would provide enough supplies for only one week of emergency care for 2 million atomic bomb casualties.

For its fiscal 1953 program, CDA is asking Congress for \$193 million for *federal* medical stockpiling. No matching funds for *local* stockpiling are requested for next year.

Ancillary News

DENTAL SECTION

BALTIMORE CITY DENTAL SOCIETY

A. BERNARD ESKOW, D.D.S.

Journal Representative

The activity of the Baltimore City Dental Society for the month of March was a meeting held at the Medical and Chirurgical Building, at which time the guest essayist was Dr. P. Philip Gross, Associate in

Oral Surgery, Graduate School and Dental School, University of Pennsylvania. His subject was "Oral Surgery for the General Practitioner." He gave a most informative and excellent presentation.

It is also to be noted that the Executive Council of the Dental Society during the month of March went on record by way of a resolution to the Mayor and City Council, endorsing the fluoridation of the Baltimore City water supply as a means of reduction of dental caries.

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Administrator*

Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations

MARYLAND LICENSED PRACTICAL NURSES ASSOCIATION

On March 25, 1952 a new association, the Maryland Licensed Practical Nurses Association, was formed. All Maryland Licensed Practical Nurses were invited to attend the meeting to organize the new Association and a large group was present. Officers were elected and the Constitution and By-laws approved. The object of the Association as stated in its Constitution is as follows:

To associate together all licensed practical nurses in Maryland for the following purposes:

1. To cultivate, promote and disseminate knowledge and information concerning practical nursing and subjects relating thereto.
2. To establish and maintain high standards of integrity, honor and character among practical nurses.
3. To furnish information regarding practical nursing and the practice and methods thereof to its members, and to the general public with respect to the practice of practical nursing.

4. To communicate with other organizations of nurses.
5. To promote vocational and social relationships among its own members, and between its own members and the members of other organizations of nurses and persons interested in nursing or related subjects.
6. To promote the welfare and interests of practical nurses, and to advance educational standards.
7. To further the efficient care of the sick and to do all things which shall be lawful and appropriate in the furtherance of any of the purposes hereinbefore expressed.

1952 BIENNIAL NURSING CONVENTION

The 1952 Biennial Nursing Convention of the three national nursing organizations will be held in Atlantic City, New Jersey, June 16-20 inclusive. Because of the impending change in the structure of these organizations, this will undoubtedly be a historic convention.

FINANCIAL AID TO STUDENT NURSES

Recently there has been much discussion about the need for financial aid to student nurses in order to increase enrollment in schools of nursing.

The Joint Committee on Nursing Information of the Joint Board of Directors of the Three Maryland State Nursing Organizations sent questionnaires to all schools of nursing in Maryland to obtain information about the need for such aid.

Nineteen schools returned questionnaires; of these, sixteen reported scholarships available; fourteen reported loan funds available. All schools had some form of financial aid available; two schools helped students only through loans.

Eleven schools stated that they needed no more scholarship aid; some of these have scholarships which are unused because they have no needy students. Six schools expressed belief that more students would be attracted to their schools if they could offer more scholarships. One school had no scholarships, but expressed a need for additional loan funds. Two schools estimated that they would like to have from 1-3 additional scholarships. One school reported loss of five applicants since September, 1951 because of lack of scholarship aid; this school estimates a need for \$5,000 in available scholarships and loan funds. Another school estimated that about 20 out of 50 students "could use" financial help. Two schools reported need for more scholarships for higher education.

Sixty-six of the scholarships offered by the various schools were described as covering "all fees," "all expenses," or "tuition and uniforms." Fifty scholarships cover part of the school expenses. Four schools offer a total of seven scholarships to alumnae for post-graduate study.

Nine hospitals offer scholarships to students in their schools; six schools have scholarships awarded by women's auxiliary organizations; six schools have scholarships awarded by the nurses alumnae associations. Seven schools reported having scholarships from individuals and organizations which were not named. Many organizations were named by one or more schools; these included: Optimist Club, Women's Civic Club, Beta Sigma Phi Sorority, American Legion, Catholic Nurses Guild, Ladies of Moose, Hibernian Society, Women's Eastern Shore

Society, Civitan Club, Zonta Club, Lions Club, Elks Club, Bruck Uniform Company, Jessie Smith Noyes Foundation, and Cooper Foundation.

This study showed that there is widespread interest in helping worthy students obtain an education in nursing. The study also seems to indicate that the needs for more scholarship aid are greatest in those nursing schools which have the largest enrollment and those which are most costly to the student.

STUDENT NURSES COUNCIL OF MARYLAND

JOAN WILLIAMS, R.N., *President*

On the 5th of March, 1952, approximately 200 student nurses representing eighteen of the twenty-one professional schools of nursing in Maryland met in Baltimore and organized the Student Nurses Council of Maryland. This Council was first started in June 1951 when the student nurses in District No. 2 of the Maryland State Nurses Association began making plans for an organization on a District level. However, in November permission was granted for the student nurses of Maryland to begin organizing on a State level with the Three Maryland State Nursing Organizations as their sponsors.

At the Mass Meeting on the 5th of March the Constitution and By-laws, which had been previously created, were approved unanimously. The election of officers was held and the results were as follows:

President, Joan Williams of Johns Hopkins; Vice-President, Barbara Matheny of Union Memorial; Recording Secretary, Peg Brown of University; Corresponding Secretary, Joanne Duffy of Mercy; and Treasurer, Bill Aikens of St. Agnes. These students, all of whom have been very active in helping to organize the Council, will hold office until May 1953.

The first step which has been taken was to have each school of nursing elect one representative to serve on the Board of Directors. A meeting of the Board of Directors is being called in the near future to discuss plans for a Florence Nightingale Service to be held during the first part of May. It is hoped that when the Membership Committee is set up, a 100% membership will be obtained from each school of nursing.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION

June 9 to 13, 1952, Chicago, Illinois

Registration: Navy Pier, at the foot of Grand Avenue

Meetings

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

MATERNAL MORTALITY MEETING

Thursday, June 26, 1952, 4:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, June 19, 1952

5:00 to 6:00 p.m.

VACCINATIONS FOR INTERNATIONAL TRAVEL

The tourist season is (along with spring) just around the corner. You and your family may have planned a foreign trip this summer. Even if you haven't some of your patients will have, and you will be called upon to administer the list of vaccinations required of travelers heading for one of the 132 countries and territories in the world.

You may secure this list from:

The Pan American Sanitary Bureau

The Regional Office of World Health Organization

1501 New Hampshire Avenue, N. W. Washington 6, D. C.

Vaccinations most generally required are against smallpox, yellow fever, and cholera, although several countries also insist on inoculation against typhoid and paratyphoid fevers, typhus, diphtheria and tetanus.

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VOLUNTARY INSURANCE

Council News, Research Council for Economic Security

Vol. II, No. 3, March, 1952

Voluntary Insurance has met almost one-third of the cost of the nation's hospital bill and one-eighth of the estimated cost of physicians' care. These percentages for 1950 represent a gain of almost 8 per cent and 5½ per cent, respectively, as compared with 1948 figures. In its report, "Voluntary Insurance against Sickness: 1950 Estimates," the Social Security Administration reveals that the amount of the nation's hospital bill paid through private resources came to approximately \$2¼ billion. About \$680 million of this total bill were paid from insurance funds. Blue Cross Plan payments accounted for \$378 million; commercial insurance company payments came to about \$254 million. The nation's medical care expenditures were estimated to be somewhat over \$2½ billion, of which voluntary insurance funds paid about \$312 million.
